STATE OF CALIFORNIA
MANAGED RISK MEDICAL INSURANCE BOARD
1000 G STREET, SUITE 450
SACRAMENTO, CA 95814

TITLE 10. INVESTMENT. CALIFORNIA CODE OF REGULATIONS
CHAPTER 5.6. ACCESS FOR INFANTS AND MOTHERS PROGRAM

NOTICE OF MODIFICATIONS TO THE TEXT OF PROPOSED REGUATIONS

Pursuant to the requirements of Government Code section 11346.8c, and section 44 of Title 1 of the California Code of Regulations, the Managed Risk Medical Insurance Board is providing notice of changes made to the proposed regulation text for sections 2699.207(d) and (e), and 2699.209 (b). Sections 2699.100; 2699.201; 2699.205; 2699.207; 2699.209; and 2699.400 were the subject of a regulatory hearing on June 3, 2008. The amendment of section 2699.207 and 2699.209 are included because they are sufficiently related to the proposed changes at that hearing.

The changes are in response to comments received regarding the proposed regulation. The changes being made are:

Section 2699.207:

Subsections (d) and (e) are being added to clarify the advance notice provided for subscribers being disenrolled from the Access for Infants and Mothers Program (AIM) for specified reasons.

Section 2699.209:

Subsection (b) is being amended to specify that it is the subscribers responsibility to notify the AIM program that her pregnancy has ended within 30 days of that date.

If you have any comments regarding the proposed changes, the Managed Risk Medical Insurance Board (MRMIB) will accept written comments between June 5, 2008 and June 19, 2008. All written comments must be submitted to MRMIB no later than 5:00 p.m. on June 19, 2008, and addressed to:

JoAnne French
Managed Risk Medical Insurance Board
1000 G Street, Suite 450
Sacramento, CA 95814

Comments may also be faxed to Ms. French at 916-327-6580, or e-mailed to her at jfrench@mrmib.ca.gov. Comments received by fax or e-mail, must also be received no later than June 19, 2008, at 5:00 p.m.

All written comments received by 5:00 p.m. on June 19, 2008, which pertain to the indicated changes will be reviewed and responded to by MRMIB as part of the compilation of the rulemaking file. Please limit your comments to the modification of the text.

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TITLE 10. INVESTMENT. CALIFORNIA CODE OF REGULATIONS
CHAPTER 5.6. ACCESS FOR INFANTS AND MOTHERS PROGRAM

AMEND SECTIONS 2699.100; 2699.201; 2699.205; 2699.207; 2699.209; and 2699.400;

ARTICLE 1. DEFINITIONS

Text proposed to be added for the 45 day comment period is displayed in underline type.
Text proposed to be deleted for the 45 day comment period is displayed in ~~strikeout type.~~
Text proposed to be added for the 15-day comment period is display in double underline type.
Text proposed to be deleted for the 15-day comment period is displayed in ~~double strikeout type.~~

Section 2699.100 is amended to read:

2699.100. Definitions

(a) "Appellant" means an applicant or subscriber who has filed an appeal with the program.

(b) "Applicant" means a pregnant woman 18 years of age or older who is applying on her own behalf, or a legal guardian or a natural parent, foster parent, or stepparent with whom the child resides, who applies for coverage under the program on behalf of a child. “Applicant” also means a pregnant woman who is applying for coverage on her own behalf who is under 18 years of age, or who is an emancipated minor, or who is a minor not living in the home of a natural or adoptive parent, a legal guardian, foster parent or stepparent.

(c) “Application Date” means the date an application is sent to the program as evidenced by the U.S. postmark date on the application envelope, or documentation from other delivery services including fax delivery.

(d) "Board" means the Managed Risk Medical Insurance Board.

(e) "Coverage" means the payment for benefits provided through the program.

(f) "Disenroll" means to terminate coverage by the program.

(g) "Eligible" means the applicant is qualified to be enrolled in a participating health plan.

(h) "Enroll" means to accept an applicant as a subscriber by notifying a participating health plan to accept the applicant.

(i) "Executive Director" means the executive director for the Board.

(j) "Family member" means the following persons living in the individual's home:

(1) Children under age 21, of married or unmarried parents living in the home.

(2) The married or unmarried parents of the child or sibling children.
(3) The stepparents of the sibling children.

(4) The separate children of either an unmarried parent or a married parent or stepparent.

(5) An unborn child of the pregnant woman who is applying for coverage on her own behalf or on whose behalf an application has been submitted.

(6) Children under the age of 21, of married or unmarried parents, away at school who are claimed as tax dependents.

(7) The spouse of the pregnant woman.

(k) "Federal poverty level" means the level determined by the “Poverty Guidelines for the 48 Contiguous States and the District of Columbia" as contained in the Annual Update of HHS Poverty Guidelines as published in the Federal Register by the U.S. Department of Health and Human Services.

(l) “First trimester” means the first 13 weeks starting with the first day of a pregnant woman’s last menstrual period and ending at the end of the 13th week, or the first 13 weeks of a 40-week, full-term pregnancy as documented by a licensed health care professional.

~~(l)~~(m) "Gross household income" means the total annual gross income of all family members except dependent children. Income includes before tax

earnings from a job, including cash, wages, salary, commissions and tips, self-employment net profits, Social Security, State Disability Insurance (SDI), Retirement Survivor Disability Insurance (RSDI), veterans benefits, Railroad Retirement, disability worker's compensation, unemployment benefits, alimony, spousal support, pensions and retirement benefits, grants that cover living expenses, settlement benefits, rental income, gifts, lottery/bingo winnings and interest income. Income excludes child support, public assistance program benefits such as SSI/SSP and CalWORKS payments, foster care payments, general relief, loans, grants or scholarships applied toward college expenses, or earned income of a child aged 13 or under, or a child attending school. Income does not include income exclusions applicable to all federal means tested programs such as, disaster relief payments, per capita payments to Native Americans from proceeds held in trust and/or arising from use of restricted lands, Agent Orange payments, Title IV student assistance, energy assistance payments to low income families, relocation assistance payments, victims of crime assistance program, Spina Bifida payments, earned income tax credit and Japanese reparation payments.

~~(m)~~(n) "Healthy Families Program" (HFP) means the Federal/State funded program that is operated pursuant to Title XXI of the Social Security Act and Part 6.2 (commencing with Section 12693) of Division 2 of the California Insurance Code, and that provides low cost health, dental and vision insurance coverage to eligible children.

~~(n)~~(o) "Income deduction" means any of the following:

(1) Work expenses of $90 per month for each family member except dependent children working or receiving disability workers' compensation or State Disability Insurance. If a family member earns less than $90, the deduction can only be for the amount earned.

(2) Child care expenses while a family member works or trains for a job of up to $200 per month for each family member under age 2, up to $175 per month for each family member over age 2 and disabled dependent care expenses of up to $175 for a disabled dependent living in the home.

(3) The amount paid by a family member per month for any court ordered alimony or child support.

(4) $50 for alimony payments received by the pregnant woman. If a woman receives less than $50, the deduction can only be for the amount received.

~~(o)~~(p) "Infant" means a subscriber's child born to a subscriber while the subscriber is enrolled in the program.

~~(p)~~(q) "Living in the home" means using the home as the primary place of residence.

~~(q)~~(r) "Medi-Cal" means the California health care services program under Title XIX of the Social Security Act.

~~(r)~~(s) "Medicare" means the Health Insurance for the aged and permanently disabled provided under Title XVIII of the Social Security Act; "Part A" means Hospital Insurance as defined in Title XVIII of the Social Security Act; and "Part B" means Medical Insurance as defined in Title XVIII of the Social Security Act.

~~(s)~~(t) "Participating health plan" means any of the following plans which are lawfully engaged in providing, arranging, paying for, or reimbursing the cost of personal health care services under insurance policies or contracts, medical and hospital service arrangements, or membership contracts, in consideration of premiums or other periodic charges payable to it, and that contracts with the program to provide coverage to program subscribers:

(1) A private insurer holding a valid outstanding certificate of authority from the Insurance Commissioner.

(2) A nonprofit hospital service plan qualifying under Chapter 11a (commencing with Section 11491) of Part 2 of Division 2 of the Insurance Code.

(3) A nonprofit membership corporation lawfully operating under the Nonprofit Corporation Law (Division 2 (commencing with Section 5000) of the Corporations Code).

(4) A health care service plan as defined under subdivision (f) of Section 1345 of the Health and Safety Code.

(5) A county or a city and county, in which case no license or approval from the Department of Insurance or the Department of Corporations shall be required to meet the requirements of this part.

(6) A comprehensive primary care licensed community clinic that is an organized outpatient freestanding health facility and is not part of a hospital that delivers comprehensive primary care services, in which case, no license or approval from the Department of Insurance or the Department of Corporations shall be required to meet the requirements of this part.

~~(t)~~(u) "Program" means the Access for Infants and Mothers Program.

~~(u)~~(v) "Resident" means a person who is present in California with intent to remain present except when absent for transitory or temporary purposes.

~~(v)~~(w) “State supported services” means abortion services provided to the subscribers through the program.

~~(w)~~(x) "Subscriber" means an individual who is eligible for and enrolled in the program.

~~(x)~~(y) "Subscriber contribution" means the cost to the subscriber to participate in the program.

~~(y)~~(z) “Tenses and Number”. The present tense includes the past and future, and the future the present; the singular includes the plural and the plural the singular.

~~(z)~~(aa) "Time". Whenever in this chapter a time is stated in which an act is to be done, the time is computed by excluding the first day and including the last day. If the last day is a holiday it is also excluded.

NOTE: Authority cited: Section 12696.05, Insurance Code. Reference: Sections 12695, 12695.06, 12695.08, 12695.18, 12695.20, 12695.22, 12695.24, 12696 and 12698, Insurance Code.

ARTICLE 2. ELIGIBILITY, APPLICATION, AND ENROLLMENT

Section 2699.201 is amended to read:

2699.201. Application

(a) To apply for the program an individual shall submit:

(1) All information, documentation, and declarations necessary to determine program eligibility as set forth in subsection (d) of this

section; and

(2) A cashier's check or money order for fifty dollars ($50.00); and

(3) A statement signed by the applicant agreeing that if the pregnant woman is enrolled, the applicant will pay the full subscriber contribution and acknowledging that the program will take aggressive action to collect the full subscriber contribution.

(b) The applicant shall sign and date a declaration stating that the information is true and accurate to the best of his or her knowledge.

(c) The applicant will be notified in writing that the application is incomplete and what documentation is required for completion.

(d) (1) The application, entitled Access for Infants and Mothers (AIM) Application ~~(rev 6/04)~~(rev 7/07), which is incorporated by reference, shall contain the following:

(A) The pregnant woman’s full name,

(B) The pregnant woman’s current living address including house or building number (and unit number if applicable), street, city, county, state, and zip code, and phone number,

(C) The pregnant woman’s date of birth,

(D) The pregnant woman’s social security number (provision of the Social Security number is not mandatory),

(E) The pregnant woman’s ethnicity and primary language (not mandatory),

(F) Certification by a staff person authorized by the Planned Parenthood Organization or a licensed or certified healthcare professional, including, but not limited to a medical doctor, doctor of osteopathy, registered nurse, physician’s assistant, nurse midwife, vocational nurse, or medical assistant, that the woman on whose behalf the application is filed is pregnant,

(G) The first day of the pregnant woman’s last menstrual period,

(H) A declaration that the pregnant woman is not, to the best of

the applicant's knowledge, beyond the 30th week of gestation in a current pregnancy, as of the application date,

(I) Information about whether the applicant or anyone in the household smokes,

(J) The address to which the bills for the subscriber's contribution are to be sent, if different from the current living address,

(K) The first and last name, and date of birth of the baby's father if living with the pregnant woman,

(L) Information about whether the father of the baby is married to the pregnant woman,

~~(K)~~(M) A list of all family members living in the home, their ages, and relationship to the pregnant woman,

~~(L)~~(N) A list of those family members, and their social security numbers excluding dependent children, living in the home who had income in the previous or current calendar year, (provision of the social security number is not mandatory),

~~(M)~~(O) Documentation of the total monthly gross household income for either the previous or current calendar year. For each person listed in (L) above, provide documentation for each source of income. Such documentation shall be provided for the previous or current year as indicated below:

1. For the previous calendar year:

   a. Federal tax return. If self-employed, a schedule C must be included.

   b. All of the following that are applicable and that reflect the current benefit amount: copies of award letters, checks, bank statements, passbooks, or internal revenue service (IRS) 1099 forms showing the amount of Social Security, State Disability Insurance (SDI), Retirement Survivor Disability Insurance (RSDI), veterans benefits, Railroad Retirement, disability workers' compensation,

unemployment benefits, alimony, spousal support, pensions and retirement benefits, loans to meet personal needs, grants that cover living expenses, settlement benefits, rental income, gifts, lottery/bingo winnings, dividends, or interest income.

2. For the current calendar year:

   a. A letter from the person's current employer. The letter shall be dated and written on the employer's letterhead, and shall include the following:

      i. The employee's name.

      ii. The employer's business name, business address and phone number.

      iii. A statement of the person's current gross monthly income for a period ending within 45 days of the date the program receives the document.

      iv. A statement that the information presented is true and correct to the best of the signer's knowledge.

      v. A signature by someone authorized to sign such letters by the employer. The signer shall include his or her position name or job title and shall not be the person whose income is being disclosed.

   b. Paystub or unemployment stub showing gross income for a period ending within 45 days of the date the program receives the document.

   c. If self employed, a profit and loss statement for the most recent three (3) month period prior to the date the program receives the document. A profit and loss statement must include the following:

i. Date.

ii. Name, address and telephone number of the business.

iii. Gross income, gross expenses, and net profit itemized on a monthly basis.

iv. A statement on the profit and loss, signed by the person who earned the income, which states, “the information provided is true and correct.”

d. A letter or Notice of Action from the County Welfare Office issued within the last two (2) months that includes:

i. For each person for whom application is being made, a statement that the person is eligible for share-of-cost Medi-Cal,

ii. A determination of total monthly household income and monthly household income after income deductions as defined in Section 2699.100, and

iii. A determination of the number of family members living in the household.

e. All of the following that are applicable and that reflect the current benefit amount: copies of award letters, checks, bank statements, or passbooks showing the amount of Social Security, State Disability Insurance (SDI), Retirement Survivor Disability Insurance (RSDI), veterans benefits, Railroad Retirement, disability workers’ compensation, unemployment benefits, alimony, spousal support, pensions and retirement benefits, loans to meet personal needs, grants that cover living expenses, settlement benefits, rental income, gifts, lottery/bingo winnings,

dividends, or interest income for the previous month.

~~(N)~~(P) The name of each family member living in the home who pays court ordered child support or court ordered alimony. The name and age of each person for whom payments are made for child care and/or disabled dependent care by a family member living in the home and the monthly amount paid. Documentation of alimony paid, child care and/or disabled dependent care expenses paid. Documentation includes copies of court orders, cancelled checks, receipts, statements from the District Attorney's Family Support Division or other equivalent document.

~~(O)~~(Q) A declaration that the pregnant woman is not a beneficiary of either no-cost Medi-Cal or Part A and Part B of Medicare,

~~(P)~~(R) A declaration that the pregnant woman has been a resident of the State of California for six (6) continuous months immediately prior to the date of the signing of the application,

~~(Q)~~(S) A declaration that the applicant will abide by the rules of participation, utilization review process, and dispute resolution process of any participating health plan in which the pregnant woman is enrolled,

~~(R)~~(T) Information about any health coverage that is in effect for the pregnant woman or will be in effect for the infant, including the name, address, and policy number of the current insurance or health plan,

~~(S)~~(U) A declaration that the pregnant woman is not, to the best of the applicant's knowledge, covered for maternity benefits in a private insurance arrangement. A pregnant woman with a separate, maternity only deductible or co-payment greater than $500 shall be deemed not covered for maternity benefits for purposes of this declaration,

~~(T)~~(V) Name~~, and~~ address and phone number of the primary employer of each adult family member who is employed,

~~(U)~~(W) Information about health coverage available to the applicant, spouse, or father of the baby who is in the household,

~~(V)~~(X) A declaration that the applicant has reviewed the benefits offered by the participating health plans,

~~(W)~~(Y) A declaration that the applicant understands and will follow the rules and regulations of the program,

~~(X)~~(Z) A declaration that the applicant is giving permission for the program to verify family income, health insurance, residence, and other circumstances,

~~(Y)~~(AA) A declaration that the subscriber is not being, and will not be, reimbursed by any health care provider or any state and local governmental entity for payment of the subscriber contribution and that no health care provider or state or local governmental entity is paying or will pay the subscriber contribution,

~~(Z)~~(BB) An indication of the pregnant woman's first choice and second choice participating health plans,

~~(AA)~~(CC) A declaration that the subscriber agrees to pay the required subscriber contribution, even if the subscriber does not take full advantage of the coverage or services.

~~(BB)~~(DD) A declaration that the information and documentation submitted is true and correct to the best of the applicant's knowledge.

(2) The Social Security number and other personal information are needed for identification and administrative purposes.

(3) If applicable, the applicant's signed authorization to forward the application to the Medi-Cal Program in the county in which the applicant resides for a determination of eligibility for no-cost Medi-Cal.

NOTE: Authority cited: Section 12696.05, Insurance Code. Reference: Sections 12698 and 12698.05, Insurance Code.

Section 2699.205 is amended to read:

2699.205. Registration of Infants

~~(a) For infants born to subscribers who are enrolled prior to July 1, 2004, the subscriber shall register the infant as follows:~~

~~(1) Within thirty (30) days of the birth of an infant, the subscriber shall notify her health plan in writing of the following information about the infant:~~

~~(A) Name; and~~

~~(B) Date of birth; and~~

~~(C) Sex; and~~

~~(D) Weight at birth~~.

~~(2) Within thirty (30) days prior to an infant's first birthday, the subscriber shall notify the program in writing if the subscriber wishes to disenroll the infant from the program. If notification is not received, the child is automatically enrolled for the second year.~~

~~(b)~~(a) For infants born to subscribers who are enrolled on or after July 1, 2004, the subscriber shall register the infant in the Healthy Families Program as follows:

(1) Upon the birth of the infant, the subscriber shall provide to the Healthy Families Program ~~the required premium and provide~~ the following information about the infant:

(A) Name; and

(B) Date of birth; and

(C) Sex; and

(D) For infants born on or after July 1, 2007:

1. Information on whether or not the infant currently is enrolled in employer sponsored health coverage and the date coverage began; and

2. Information on whether or not the infant was previously enrolled in employer sponsored health coverage, the date coverage began, the date in which coverage terminated, and the reason for termination.

(2) The Healthy Families Program shall request the infant's birth weight and primary care provider from the subscriber.

(3) Subject to all requirements specified in the statute and regulations governing the Healthy Families Program, the infant will be enrolled in the Healthy Families Program with coverage effective on the date of the infant's birth.

NOTE: Authority cited: Section 12696.05, Insurance Code. Reference: Sections 12693.765 and 12696, Insurance Code.

Section 2699.207 is amended to read:

2699.207. Disenrollment

(a) A subscriber ~~and/or infant~~ shall be disenrolled from the program and from the program's participating health plan when any of the following occur:

(1) The subscriber so requests in writing.

(2) The subscriber becomes ineligible because:

(A) The subscriber fails to meet the residency requirement; or

(B) The subscriber has committed an act of fraud to circumvent the statutes or regulations of the program,

(C) The subscriber is no longer pregnant on her effective date of coverage. If notification to the program is received after the effective date, documentation by a licensed or certified healthcare professional must be submitted indicating the date of the miscarriage.

(D) More than 60 days have elapsed since the end of the pregnancy for which the subscriber enrolled in the program. As a condition of receiving the premium reduction described in Section 2699.400(a)(5), documentation by a licensed or certified healthcare professional must be submitted to the program indicating the date the pregnancy ended.

~~(3) The infant becomes ineligible because the infant fails to meet the residency requirement.~~

(b) ~~A subscriber shall be notified by the program in writing of the disenrollment of the subscriber and/or infant from the program, the effective date, and the reason for the disenrollment.~~
When a subscriber is disenrolled pursuant to subsection (a) of this section, the program shall notify the subscriber of the disenrollment. The notice shall be in writing and include the following information:

(1) The reason for the disenrollment.

(2) The effective date of the disenrollment.

(3) An explanation of the appeals process.

(c) ~~Except for Section 2699.207(a)(2)(C), disenrollment shall take effect at the end of the calendar month in which the request was received or at the end of a future calendar month as requested by the applicant. Disenrollment pursuant to Section 2699.207(a)(2)(C) shall take effect upon the date that would have been the effective date of coverage.~~
Disenrollment pursuant to (a)(1), shall take effect at the end of the calendar month in which the request was received or at the end of a future calendar month as requested by the subscriber.

(d) Disenrollment pursuant to (a)(2)(A), shall take effect as follows:

1. If the program provides notification to the subscriber on or before the 10th of the month, disenrollment shall take effect at the end of the calendar month.

2. If the program provides notification to the subscriber after the 10th of the month, disenrollment shall take effect at the end of the following calendar month.

(e) Disenrollment pursuant to (a)(2)(B), shall take effect as follows:

1. If the program provides notification to the subscriber on or before the 10th of the month, disenrollment shall take effect at the end of the calendar month.

2. If the program provides notification to the subscriber after the 10th of the month, disenrollment shall take effect at the end of the following calendar month.

(f) Disenrollment pursuant to (a)(2)(C), shall take effect upon the date that would have been the effective date of coverage.

(g) Disenrollment pursuant to (a)(2)(D), shall take effect on the 61st day following the date the subscriber's pregnancy ended.

~~(d)~~(h) Once a subscriber ~~and/or infant~~ is disenrolled pursuant to Section 2699.207(a), the subscriber ~~and/or infant~~ cannot be re-enrolled for the same pregnancy.

NOTE: Authority cited: Section 12696.05, Insurance Code. Reference: Sections 12696.05 and 12698, Insurance Code.

Section 2699.209 is amended to read:

2699.209. Coverage

(a) The date on which the coverage shall begin shall be no later than ten (10) calendar days from the date the applicant is enrolled. Coverage shall not begin if the pregnancy terminates prior to the effective date of coverage.

(b) Unless the subscriber is otherwise disenrolled pursuant to Section 2699.207, ~~Coverage~~coverage in the program for the subscriber shall be for one pregnancy and shall include services following the pregnancy for sixty (60) days. ~~The subscriber shall be notified of the date her coverage ends and such notice will be provided at least twenty (20) days prior to that date.~~ The subscriber shall notify the program of the date on which the pregnancy for which she enrolled ends. She shall provide this notification by the thirtieth day after the end of the pregnancy.

~~(c) Coverage in the program for an infant born to a subscriber who is enrolled prior to July 1, 2004 shall be for two (2) years from the date of the birth of the child.~~

~~(d) Notwithstanding subsections (b) and (c) above, coverage in the program for either the subscriber or the infant will cease at disenrollment~~.

NOTE: Authority cited: Section 12696.05, Insurance Code. Reference: Sections 12696.05 and 12698.30, Insurance Code.

ARTICLE 4. SUBSCRIBER CONTRIBUTIONS AND PAYMENT FOR SERVICES

Section 2699.400 is amended to read:

2699.400. Subscriber Contributions

(a) Subscriber contributions shall be:

(1) An initial fifty dollars ($50.00) to be submitted with the application; and

(2) For subscribers who are enrolled prior to July 1, 2004, the difference between two percent (2%) of the subscriber's gross household income, less deductions, as documented with the application and fifty dollars ($50.00), which amount shall be due in twelve (12) equal monthly installments beginning with the first month following enrollment; and

(3) For infants born to subscribers who are enrolled prior to July 1, 2004, one hundred dollars ($100.00) which shall be due on the infant's first birthday unless either of following apply:

(A) The infant is disenrolled from the program prior to the infant's first birthday, or

(B) The subscriber provides written proof that the infant is current for the infant's first year immunizations. Such immunizations shall be consistent with the most current version of the Recommended Childhood Immunization Schedule jointly adopted by the Advisory Committee on Immunization Practices, the American Academy of Pediatrics, and the American Academy of Family Physicians. The written proof of completed current first year immunizations shall be signed by a licensed medical doctor, licensed doctor of osteopathy, registered nurse, or licensed physician's assistant. When such written notice is provided the amount shall be fifty dollars ($50.00).

(4) For subscribers who are enrolled on or after July 1, 2004, the difference between one and one-half percent (1.5%) of the subscriber's gross household income, less deductions, as documented with the application and fifty dollars ($50.00), which amount shall be due in twelve (12) equal monthly installments beginning with the first month following enrollment.

(5) (A) For subscribers who are enrolled on or after July 1, 2008, and no longer pregnant by the end of their first trimester, the subscriber contribution shall be reduced and shall be one-third (1/3) of the subscriber contribution calculated pursuant to subsections (a)(1) and (a)(4) of this section.

(B) As a condition of receiving this reduction, documentation by a licensed or certified healthcare professional must be submitted to the program indicating the date the pregnancy ended.

(b) There shall be no penalty for early payment of any portion of the subscriber contribution.

(c) In cases of multiple births to a subscriber, the $100 payment shall apply to each infant born to a subscriber who is enrolled prior to July 1, 2004.

(d) Subscribers shall not be reimbursed by any health care provider or state or local governmental entity for payment of the subscriber contribution and shall not have any health care provider or state or local governmental entity pay the subscriber contribution.

(e) No portion of the subscriber contribution is refundable except as provided in Sections 2699.202 and 2699.203, ~~or~~ unless the subscriber is disenrolled pursuant to Subsection 2699.207(a)(2)(C), or unless the subscriber contribution is reduced pursuant to Section 2699.400(a)(5).

(f) A federally recognized California Indian Tribal Government may make required subscriber and infant contributions on behalf of a member of the tribe.

(g) An applicant in arrears of subscriber contributions shall be sent a reminder notice. Applicants who become ninety (90) days in arrears on subscriber contributions will be reported to a credit reporting agency. If accounts are paid in full at a later date, the credit reporting agency's records shall be updated.

NOTE: Authority cited: Section 12696.05, Insurance Code. Reference: Sections 12696, 12696.05, and 12698, Insurance Code.

The California Managed Risk Medical Insurance Board
1000 G Street, Suite 450
Sacramento, CA 95814
(916) 324-4695 FAX: (916) 324-4878

DATE: June 23, 2008

TO: Managed Risk Medical Insurance Board Members

FROM: Lesley Cummings, Executive Director

SUBJECT: Access for Infants and Mothers (AIM) Program Reduced Subscriber Contributions Following First Trimester Miscarriage Regulations

Staff requests that the Board adopt the final Access for Infants and Mothers (AIM) regulations (R-2-08). The purpose of the regulations is to reduce subscriber contributions for AIM subscribers who experience a first trimester miscarriage and to clarify procedural requirements.

On December 19, 2007, the Board considered proposed regulations authorizing reduced subscriber contributions for AIM subscribers following first trimester miscarriages, along with changes spelling out the disenrollment date for various categories of subscribers. This was the first public viewing of the proposed regulations. On January 16, 2008, MRMIB adopted the proposed regulations for filing with the Office of Administrative Law (OAL) and the Board directed staff to work with advocates regarding their concerns about issues that were beyond the scope of the regulations. On April 28, 2008, MRMIB released the Notice of Proposed Rulemaking and held a public hearing on the proposed regulations on June 3, 2008.

Based on public testimony at the June 3, 2008, public hearing and written public comments, MRMIB released a supplemental Notice of Proposed Rulemaking modifying the text of the original proposed regulations on June 4, 2008 and provided the required 15-day opportunity for additional public comment.

The final version of the regulation is included in Agenda Item 10.d.5., which is attached to this memorandum. The changes that were made by the originally-proposed regulations are shown in underline and strikethrough mode; additional changes proposed in the June 4, 2008 supplemental Notice of Proposed Rulemaking are shown in double underline and double strikethrough mode.

In order for these regulations to take effect, the Board must adopt the final regulation language, which staff will then file with OAL.

Agenda Item 10.d.2.
6/23/08 Meeting

PUBLIC HEARING

BEFORE THE

CALIFORNIA MANAGED RISK MEDICAL INSURANCE BOARD

In the Matter of:	
Notice of Proposed Rulemaking R-2-08 Title 10, California Code of Regulations, Chapter 5.6, Access for Infants and Mothers Program	Amend Sections 2699.100; 2699.201; 2699.205; 2699.207; 2699.209; 2699.400

SUITE 450

1000 G STREET

SACRAMENTO, CALIFORNIA 95814

TUESDAY, JUNE 3, 2008

9:02 A.M.

Reported by:
Peter Petty

MANAGED RISK MEDICAL INSURANCE BOARD

Randi Turner, Chief, Human Resources and Program Support

JoAnne French

ALSO PRESENT

Lucy Quacinella, Attorney, Principal
Multiforum Advocacy Solutions
on behalf of Maternal and Child Health Access

Anne Marie Benitez, Public Policy Director
Planned Parenthood Affiliates of California, Inc.

I N D E X

P R O C E E D I N G S

9:02 a.m.

HEARING OFFICER TURNER: Good morning. This hearing is being recorded electronically. The transcript of the hearing and all exhibits and evidence presented during the hearing will be made part of the rulemaking record.

The rulemaking record includes the notice of the proposed action, which was published in the California Regulatory Notice Register; the express terms of the proposed action, using underline-and-strikeout form of the California Code of Regulations; and the statement of reasons; and the written comments that are received to date.

I'm Randi Turner; I'm the Chief of Human Resources and Program Support, which includes the regulations unit, for the Managed Risk Medical Insurance Board.

Today is Tuesday, June 3rd, and it is about 9:02 a.m. We're meeting at the Offices of the Managed Risk Medical Insurance Board, 1000 G Street, Suite 450, Sacramento, California, in the front conference room for the purpose of receiving public comments on a proposed rulemaking action by the Board to make changes to chapter 5.8 (sic) of Title 10 of the California Code of Regulations.

Evidence in writing from interested parties will be accepted until 5:00 p.m. today. Any comments received after 5:00 p.m. will be considered late comments and will

not be accepted.

And, Lucy, you said you already brought written comments with you that we'll accept when you're finished speaking.

The Access for Infants and Mothers program was established in 1991 to provide health insurance to low and moderate income pregnant women and the infants born to the covered women. AIM is the acronym for this program. It is a means-tested program covering pregnant women with family incomes above 200 percent, but not more than 300 percent of the federal poverty level.

Women with family incomes below 200 percent federal poverty level qualify for no-cost MediCal services for the pregnancy, funded by the state and federal dollars.

Currently the AIM program requires the subscriber to pay the full contribution rate of 1.5 percent during the term of their pregnancy regardless of when the subscriber is no longer pregnant, after their effective date of coverage.

The propose regulation changes state that subscribers enrolled on or after July 1, 2008, who are no longer pregnant by the end of their first trimester will not be subjected to pay the entire 1.5 percent contribution. Instead, their subscriber contribution will be reduced to one-third of the current 1.5 percent subscriber contribution.

Under the provisions of the California Administrative Procedures Act, this is the time and place set for the presentation of statements, arguments and contentions orally or in writing, for or against the changes in the Board's regulations.

The notice of this proposal has been published on MRMIB's website, in the California Regulatory Notice Register and has been sent by mail to interested parties.

This is a quasi-legislative hearing to carry out the rulemaking functions delegated to the Board by the Legislature. Witnesses presenting testimony at this hearing will not be sworn in, nor will they engage in cross-examination of witnesses.

We will take under submission all written and oral statements submitted or made during this hearing. We will respond to these comments in writing in the final statement of reasons.

We will notify all those who signed in and provided addresses before the final adoption of any changes to this proposal, or about any new material relied upon in proposing these regulations.

Such notice will be sent to everyone who submits written comments during the written comment period, including those written comments submitted today, to everyone who testifies today -- excuse me -- and to everyone

who asks for such notification.

While no one may be excluded from participation in these proceedings for failure to identify themselves, the names and addresses on the attendance sheet will be used for provide the notice. Normally I would say if you've not yet signed in and want to do so, let me know. But we know you've done that.

We will listen to oral comments in the order signed on the attendance sheet. After we hear from everyone who signed in, we will hear from any latecomers or anyone else who wishes to be heard.

When you speak, please begin by stating your name and identifying the organization you represent, if any; and tell us the section number of the particular regulation you want to discuss.

So, at this point we're ready to take oral comments. And we're ready, this is Lucy Quacinella?

MS. QUACINELLA: Quacinella.

HEARING OFFICER TURNER: Quacinella, okay. And why don't you go ahead and present your testimony.

MS. QUACINELLA: Thank you. Before I forget, this is our written packet of materials. And I do have a few extra copies if you think they're useful.

HEARING OFFICER TURNER: Sure. Thank you.

MS. QUACINELLA: Okay, thank you. My name is Lucy

Quacinella. I'm here today on behalf of Maternal and Child Health Access, which is a community based organization in Los Angeles that also does statewide health policy work.

We have a number of issues that we would like to address in this regulation filing. I will try to remember to mention the specific regulation number for each issue. But if I neglect to do that in my verbal comments, please know that in our written comments we have organized the comments based on the specific regulation sections and proposed changes to each section.

First of all, we'd like to thank MRMIB for the one change in this filing that we think is quite positive, and that is the decision to make a partial reduction in the subscriber contributions for women who miscarry after the effective date of coverage, on or after the effective date of coverage, but before the end of the first trimester.

We are somewhat disappointed that this new beneficial rule is limited to the first trimester. We think it should be applied, as well, to the second trimester. We fail to see the necessity for the restriction limiting the reduction to first-trimester miscarriages, especially since the science of dating the beginning of a pregnancy and/or the exact end of a trimester is not exact; it's not precise.

And so we believe that a much more logical and practical rule would be, as well as a more fair and just

rule, would be to allow all of the women who miscarry in the first or second trimester to benefit from the reduction.

But that said, we are appreciative of the progress that has been made, at least for women in that first trimester.

My next series of comments includes a different issue. I'd like to begin by saying that we think the notice of rulemaking and the informative digest and the way this regulation filing have been framed are quite misleading. Not intentionally, but I think the actual effect is that any person who's been following this issue, and who's seen this regulation filing and read the notice, even if they've come to the hearing today and followed the signs, very helpful signs, on G Street, all the way up to the fourth floor, this whole thing is being billed as the first trimester rule, first trimester miscarriage.

And I think that the informative digest, as well as all of this other framing around this filing, would lead one to reasonably conclude that the only issues here are the premium reduction that we've just discussed.

When, in fact, a very close technical reading of the regulation filing discloses a much bigger issue affecting many more women. On the one hand, I think the staff estimate is that there are approximately 60 women enrolled in AIM a year who may miscarry during the first

trimester.

And while it's, of course, helpful and important to assist those 60 women with a premium reduction, on the other hand there are about 11,500 women enrolled in AIM each year. And this other broader issue affects every single one of those women.

So we think it would be really helpful and important if the Board were to reconsider the issue that I'm about to get specific about, and reframe the way this issue is raised, and have a much broader discussion.

The particular -- so, just, you know, for the record, it's in our written comments, but we believe that the Administrative Procedures Act requirements for notice have not been complied with because of the way this filing has been framed. In a limited fashion, to lead the reasonable reader to conclude that the only issue of substance here is the first trimester miscarriage subscriber contribution reduction.

The other issue, then, that we think is overwhelming here, and that affects all women enrolled in AIM, is the proposal in subdivision .209(b) -- I guess all of these regs are section 2699, 2699, so the regulation that we're most concerned with today, that my client is most concerned with today is .209(b).

If it's helpful to refer you to the page, I think

that's at page 15. Subdivision (b), the last sentence there, the proposal is to strike out the sentence that reads: The subscriber shall be notified of the date her coverage ends and such notice will be provided at least 20 days prior to that date."

We have a major concern here with the strike of a pen, or computer keystroke, I guess, computer keystroke, AIM's existing 20-day-prior-notice requirement is proposed for elimination. And that's huge. And that's a major change in the way the program, at least, you know, in writing in the regulations, has been meant to operate to date.

Now, my client would not be concerned about this change if it didn't have such major impacts for all of the women in AIM. Prior notice that your publicly funded benefits are about to end, as well as your health insurance in your health plan, prior notice of that change is a fundamental part of due process.

And, you know, another way to describe due process is really fundamental fairness. And an opportunity, on the one hand, to prepare for the change. And on the other hand, to express any objection that the woman may have to the fact that the state plans to end her AIM benefits and to disenroll her from her health plan.

For example, one of the reasons in the long-

standing regulations, and this reason is retained in a different section of the regulations, for ending AIM benefits and disenrolling a woman is if the program believes she's somehow committed fraud.

Well, under the current regulations that woman is entitled to prior notice at least 20 days in advance in writing that AIM thinks she's committed fraud, and that AIM plans to disenroll her.

Well, with that 20-day notice the woman can make some important choices. She can decide well, you know, I really shouldn't have said what I said; I'm just going to leave it at that. And I know that, you know, my health insurance is over.

But much more common, in my experience as a consumer advocate, is that there can be misunderstandings about what a woman may or may not have indicated on her application. What she may or may not have said to someone at the call center. What may or may not be in the written documentation that she submitted in support of her AIM application.

So, in this example where a woman's AIM benefits are to be terminated and her health insurance is to end, she has a constitutional right, as well as a right under state and federal regulation, to that prior notice and an opportunity to tell her side of the story before her health

benefits during pregnancy end.

There are many other examples where there could be factual disputes where the woman should have an opportunity to present her side of the case.

The new proposed premium reduction provision for first trimester miscarriages is another example. It is a situation in which the woman will be disenrolled from AIM if she miscarries, effective 60 days postpartum. But her right to that subscriber contribution and the day on which her health benefits end may be a question of fact.

Perhaps the program believes that her first trimester ends on, you know, June 30th. But she and her doctor believe it's really more like July 5th. Now, five days may not seem like a lot, but in these situations it can make a world of difference.

In some miscarriages it's not entirely clear when the pregnancy is really over. It's not uncommon that the process begins on one day and may end on another day. It may be the following day, it may be two or three days. There can be complex issues of medical fact.

And I want to underscore here that it's not the amount of the subscriber contribution reduction that's so important. Yes, that's helpful. These are low-income working families. Every dime they get to keep makes a world of difference to them.

But the bigger potential financial burden is from losing the health insurance. And especially in a case where there's been, you know, complicated medical factors related to the miscarriage. The woman's need for medical care, you know, may be ongoing. And just a week's more worth of coverage could help see her through that crisis.

So those are two examples where the state is alleging that a woman has committed fraud or some other thing that means she is no longer eligible for AIM in the state's view. The woman may challenge the state's version of the facts.

Another example is where there's been a miscarriage and there are issues both about whether the woman is eligible for the subscriber contribution reduction based on when the miscarriage occurred, and when that 60th day postpartum is going to occur, and, hence, signal the end of her coverage.

But another situation where it's extremely important for women to get -- I want to underscore to continue to have the right to receive the 20-day prior notice, because AIM's existing regulations clearly say in 2699.209(b) that all subscribers are entitled to at least 20 days prior notice before their coverage ends.

Every single woman enrolled in AIM, and that's, you know, around 11,500, at present has that right. Under

these regulations none of the women would have that right.

So, in the situation where a woman fortunately has, you know, carried her pregnancy to term, and she's given birth to a healthy child, it's also important then that the woman be informed by the state that her benefits are going to end effective the 60th day postpartum.

People need to prepare. It can be the case that a woman might make a medical appointment, schedule a medical appointment for after the 60th day postpartum. It might be something related to the pregnancy or it might not, because AIM provides comprehensive health insurance.

So, you know, maybe she's had a problem with one of her hands. And she's made an appointment to get that taken care of now that, you know, the baby's home and all that's set up and running.

If she's not insured it's obviously in her interest to know and understand that so that she can act accordingly. AIM is very different from other programs in that most subscribers don't take the option, because they can't afford it, to pay upfront for their 12 months of subscriber contributions. Instead most of the women are billed each month. And so they pay their complete 1.5 percent of gross income spread out over 12 installment payments.

So that even after the pregnancy has ended, and

the postpartum period is over, the woman may still be -- will, in fact, continue to receive monthly demands for payment from the AIM program until that 12-month period has played itself out.

So it can be very confusing for the women. They get these, you know, notices from the state every month. They think of them as their, you know, bills for their insurance premiums. And when they send the money in and they make their payment, they're in the frame of mind that they've paid for health insurance.

So the existing 20-day prior notice rule serves the important purpose of notifying the women that their coverage is about to end, and that they should prepare accordingly.

Part of the reason why this is so important is that AIM operates through managed care health plans. And there's lot of opportunity for poor communication amongst providers, plans, the state and the woman. There are four parties here who have to get their act together.

And if everything doesn't go, you know, exactly right, the woman can continue, if she's, you know, not clear that 60 days postpartum signals the end of her coverage, her provider's not paying attention, the health plan's just humming along, doing what it does, then the person in this whole system who stands to lose the most and who can least

afford to lose anything is that woman.

The way the program operates is that AIM does not review the women's cases to find out what has happened with their pregnancies until 11 months after the date of application.

So, you could have a woman who enters the program, you know, let's say in her third month of pregnancy; delivers a baby, you know, six months later. But the AIM program will not review that woman's case until a total of 11 months have elapsed from the date of her application. And that can be a very long time.

And if the woman isn't notified at least 20 days before her coverage is about to end, she may continue using her health plan card until that 11th month review.

And, you know, the health plan will continue to treat her as an enrollee. Her provider will continue to treat her as an enrollee. She will be getting monthly billing statements from the AIM program. So, from her perspective, the AIM program is treating her as an ongoing enrollee. She makes her monthly payments on time. And so she thinks, you know, I'm in this deal, I've got my insurance.

And then lo and behold, at the 11th month, if the program finds her baby was delivered many months earlier, she will be disenrolled retroactive to the 60th day

postpartum.

And this is especially dangerous for the women because any health care that they may have received in the interim then becomes billed directly to the woman. And the rate of the billing is significantly higher than what any insurance company or the AIM program would pay for the exact same health insurance.

It's a well known fact in the industry that what's referred to as cost-shifting occurs. In other words, uninsured patients who go to a hospital, for example, emergency room, will be billed at a much higher rate than would have been billed to their insurance company if they had been insured.

So, a woman could end up literally with, you know, tens of thousands of dollars in medical debt because of this misunderstanding, because there hasn't been coordination among the plan, the providers and the administrative offices of the AIM program.

And the person who will feel the brunt of that is the woman, herself, in very significant ways. Medical debt is one of the leading reasons in the country today for bankruptcy. And these women are at risk at becoming part of those statistics.

Again, you know, I want to link this all back to the proposed change to section 2699.209(b). That 20-day

prior notice requirement for all of the women, not just those who -- hi -- miscarry, but for all of the women is very important.

One final point I'd like to make is that the Administrative Procedures Act requires state agencies, before they make changes to their regulations, to consider alternatives. And I think it's fair to say that the requirement is that reasonable alternatives be considered.

I understand that the Board has, or may have, considered some alternatives here. But I really do not believe that the MRMIB Board was fully aware of the impact for all of the women in the AIM program of this proposed repeal of the 20-day prior notice requirement.

And that if the Board had been made fully aware of all the impacts for the women who are being disenrolled for cause, for the women who may have a legitimate medical dispute about the exact date of the end of their pregnancies, and the interface between the 11th month reviews and the impact on all women enrolled in AIM, if there had been a full discussion before the Board about all of these issues, rather than just the narrow focus on the subscriber contribution reduction, we may have had a very different regulation packet.

So, in the spirit of the Administrative Procedures Act my client would like to offer two alternatives that we

do not believe have yet been considered by the Board. And hopefully a full consideration of these new alternatives will be something that the AIM program thinks has merit, and that can help us all resolve this controversy with respect to the repeal of the 20-day prior notice requirement.

The first proposed alternative, and again these are all in the written comments that we submitted today, but the first proposed alternative is to look at the existing practice. It's not a regulation, to my understanding, it's just a practice that the AIM program waits until 11 months have passed from the woman's application date to review her case.

I think many of the problems that I've described today result from this long delay where the coordination amongst the plan, the provider, the woman and the AIM administrative apparatus is left for 11 months.

If there were earlier reviews then the end of pregnancy would be flagged to the administrative system earlier. And that could go a long way to resolving the difficulties here.

Our specific proposal is that the reviews be conducted after the woman's estimated due date, but before the end of the estimated 60-day postpartum period. As part of the AIM application process, the women are required to answer a question about what their estimated due date is.

So that information should be available in every single one of the cases.

Now we, of course, acknowledge that estimated due dates are exactly that, they are estimates. So, you know, they're not going to be precise for every single woman. But there is that at least 60-day window between the date the woman gives as her estimated due date and then 60 days later, which would signal the end of the 60-day postpartum period if the delivery did occur on the estimated due date.

We believe that instead of waiting 11 months from the date of application, if instead the program reviews occurred sometime after the estimated due date. And we'd leave, you know, to the Board's administrative staff to consider what the best date would be. Just one possible suggestion to us, 10 days, 10 days from the estimated due date seems like a reasonable time to start checking in to ask the question of the health plans, you know, has there been a delivery here. Was there a miscarriage; was a baby born.

And then within that timeframe there's ample opportunity to issue the 20-day prior notice of termination of AIM benefits and health plan coverage. So that we could, as I believe fundamental due process requires we must, retain the existing provision in section 2699.209(b) that requires the 20-day prior notice, but still have the program

review process proceed.

So, you know, in some ways it's just a slight change. Instead of tickling all of these cases for 11 months from the date of application, AIM would, instead tickle them for 10 days, 15 days, whatever the program thinks is most appropriate -- bless you -- from the estimated due date.

The second alternative is related, but different. If, for some reason, the Board were to decide that this proposal of conducting the case reviews within a short period following the estimated due date were not the way to go because estimates are too much like estimates, they're not precise enough.

Then an alternative could be to conduct the reviews on a date-certain that is much earlier, however, than 11 months from the date of application. And a reasonable time period to us would seem to be an additional 60 days after what would have been the end of the 60-day postpartum period had the delivery occurred on the actual estimated due date.

And so in order words, there would be a total of 120 days from the estimated due date. And if the estimated due date, you know, was off, whether it was earlier or later, the program would still operate with a situation in which the program reviews would be conducted on that date

certain.

And the plans would know this; you know, they would know that instead of having the reviews happen 11 months from the date of application, they're going to happen on a different timeframe.

And there we'd pick up any potential problems much earlier. And we would also, of course, need to retain the 20-day prior notice of termination rule that's a fundamental precept of constitutional due process. The federal regulations require it. There's really no reason why the state regulations should be inconsistent with the federal regulations, or with the federal or state constitution on this point. And so that alternative could accommodate those concerns, as well.

HEARING OFFICER TURNER: Thank you.

MS. QUACINELLA: Yeah. I'm just going to take a quick minute here to review my notes to make sure I haven't neglected to mention any other important points.

There is one point I would like to add. This is a separate issue, but it's very much related to the comments that have just been made.

The specific situation I'd like to focus on now is the situation in which a woman has applied for AIM; the program has reviewed her application and all of her supporting documentation and verifications. And the AIM

program has made a specific finding of eligibility for that woman.

And the woman then is sent -- the woman selects her health plan in those counties where she gets a choice; in some counties there is no choice, they're just enrolled in, you know, whatever's available. But whether this is, you know, a single-plan county or one in which there's choice, the woman has made her choice and she's been enrolled. And she receives her health plan card.

But in this woman's situation unfortunately she has a miscarriage before the effective date of coverage. There can be as much as a 20-day window between the day a woman applies for AIM and the day that her health plan coverage goes into effect.

And under the existing program rules if the woman is so unlucky as to not only miscarry, but to have that miscarriage occur before the effective date of coverage, then the program treats her as thought she never applied at all. Or as though she were found ineligible. And she has no health care insurance for any of the medical care related to the miscarriage, or any of the medical care postpartum.

And this is just a travesty of justice, and a real tragedy for the women, because in this situation we know in most cases, you know, maybe not all, but in most cases where there's been a miscarriage some kind of medical visit, you

know, will be necessary.

And even women who really can't afford to pay out of pocket, and know they can't afford to pay out of pocket, may find themselves in a situation where they have to go to an emergency room. You know, it may be as serious as a life-threatening condition. But even if it's not life threatening, you know, when you're bleeding and you're pregnant, if you call a provider most providers are going to comply with the standard of care, which is, you know, get yourself to an emergency room right away.

And in these situations the woman is treated by AIM as if she never applied, was never found eligible and never had a single day of health insurance coverage, simply because of the uncontrollable circumstance of the day her miscarriage occurred.

So, we believe, at a minimum, that these women should also receive the benefit of the 20-day prior notice of termination of benefits and disenrollment from health plan rule.

Thank you.

HEARING OFFICER TURNER: Thank you. Okay, before we go on I'd like to correct my opening statement. I read to you that we were making comments on chapter 5.8 of Title 10. We're actually making comments on chapter 5.6, which are the AIM regulations.

And since Lucy began speaking we have Ann Marie Benitez --

MS. BENITEZ: Benitez.

HEARING OFFICER TURNER: -- Benitez, sorry, who has signed in. If you would please introduce yourself and name your organization before you begin speaking, that would be helpful.

MS. BENITEZ: My name is Ann Marie Benitez with Planned Parenthood Affiliates of California. I'm the Public Policy Director of Planned Parenthood. And my comments will be really short.

I just wanted to reiterate my colleague's comments, and say that we're in support of many of the things already iterated here at the hearing.

Specifically we wanted to highlight our two major concerns that have been brought up in the proposed rulemakings.

The first one being we really truly appreciate that MRMIB went ahead and did a rebate for women who experience a miscarriage in the first trimester. However, we believe that this should be applied to all women regardless of when they have their miscarriage.

The reason why we believe this is because the exclusion of women in the second trimester is, the date of when the first trimester ends and the date when the second

trimester begins can depend and vary amongst each pregnant woman.

And furthermore, later miscarriages are often exceedingly traumatic to women because they have a longer period of time with their pregnancies; and continuing to bill women for their pregnancy-related coverage poses already a very difficult time for them.

Secondly, we also are concerned about the elimination of the existing 20-day prior notice of determination of AIM benefits and health plan coverage. We believe this should stay in the regulation.

It's critical to provide prior notice to be given to all AIM beneficiaries women before termination of coverage. I think this is critical for all types of health coverage. And these women shouldn't be treated differently.

So those are our two major concerns that I wanted to highlight. I've recently emailed our concerns to Jennifer French --

MS. FRENCH: JoAnne.

MS. BENITEZ: Yeah, JoAnne, sorry.

MS. FRENCH: You emailed that letter to me?

MS. BENITEZ: I just emailed it this morning, so you have our written comments.

HEARING OFFICER TURNER: Okay.

MS. BENITEZ: Thank you.

HEARING OFFICER TURNER: Thank you very much. Thank both of you for coming.

MS. QUACINELLA: Actually I did have one other clarification to make, if I may?

HEARING OFFICER TURNER: Sure.

MS. QUACINELLA: I did want to note for the record that various organizations have joined in with the comments of maternal and child health access. And later today we may have additional sign-ons. So I just wanted to give Ms. French the heads-up that perhaps you may be seeing a longer list of sign-ons. But the comments will not have changed.

And the organizations signing on with maternal and child health access are the American College of Obstetricians and Gynecologists, District Nine, which, of course, includes California; the California Medical Association; the Center for Public Interest Law; Childrens Advocacy Institute; the Los Angeles Best Babies Network; Planned Parenthood Affiliates of California, and my colleague here today.

Thank you.

HEARING OFFICER TURNER: Thank you. Okay, just be sure if you do send them that they're here before 5:00, okay?

MS. QUACINELLA: Right. And email is acceptable, is that correct?

HEARING OFFICER TURNER: Email or fax, yeah. Just received by 5:00 on the dot.

Yes, do you have a business card or --

MS. BENITEZ: Yes, I do.

HEARING OFFICER TURNER: I know you're kind of --

MS. FRENCH: Could I just make a copy --

MS. QUACINELLA: Do you need help getting --

For the record, Ms. Benitez is making an heroic effort to use her arms today.

HEARING OFFICER TURNER: Thank you. All right, thank you both for coming.

MS. QUACINELLA: Thank you.

MS. BENITEZ: Thanks very much.

MS. QUACINELLA: Thanks for listening.

MS. BENITEZ: Yes.

HEARING OFFICER TURNER: You're welcome.

Okay, and that concludes our testimony.

(Whereupon, at 9:45 a.m., the hearing was adjourned.)

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CERTIFICATE OF REPORTER

I, PETER PETTY, an Electronic Reporter, do hereby certify that I am a disinterested person herein; that I recorded the foregoing Managed Risk Medical Insurance Board Public Hearing; that it was thereafter transcribed into typewriting.

I further certify that I am not of counsel or attorney for any of the parties to said hearing, nor in any way interested in outcome of said hearing.

IN WITNESS WHEREOF, I have hereunto set my hand this 3rd day of June, 2008.

List of Comments Received

Eight (8) organizations collaboratively submitted one public comment made in writing regarding the proposed regulations. This comment will be referenced as the "8 group letter" and was signed by:

- Maternal and Child Health Access – Lynn Kersey
- Maternal and Child Health Access – Lucy Quacinella
- American College of Obstetricians and Gynecologist District IX – Shannon Smith-Crowley
- California Medical Association – David Ford
- Center for Public Interest Law Children's Advocacy Institute - Robert Fellmeth
- LA Best Babies Network – Carolina Reyes
- Planned Parenthood Affiliates of California – Lilly Spitz
- Health Service Agency – Barbara Rice

Three (3) organizations collaboratively submitted one public comment made in writing regarding the proposed regulations. This comment will be referenced as the "3 group letter" and was signed by:

- The Children's Partnership – Wendy Lazarus
- Children Now – Ted Lempert
- Children's Defense Fund-California – Cliff Sarkin

Additional written comments were received by:

- Planned Parenthood Affiliates of California, Inc – Ann Marie Benitez
- California Primary Care Association - Molly Brassil
- LA Best Babies Network - Caroline Reyes
- ACCESS/Women's Health Rights Coalition – Destiny Lopez
- Asian Law Alliance – Jacquelyn K. Maruhashi

Oral comments were received by:

- Maternal and Child Health Access – Lucy Quacinella
- Planned Parenthood Affiliates of California, Inc – Ann Marie Benitez

Three (3) organizations collaboratively submitted one public comment to the 15-Day notice made in writing regarding the proposed regulations. This comment will be referenced as the "15-Day group letter" and was signed by:

- Maternal and Child Health Access – Lynn Kersey
- Maternal and Child Health Access – Lucy Quacinella
- Asian Law Alliance – Jacquelyn K. Maruhashi

Specific Comments and Responses

1) The comment immediately below was received by:

Written Comment
- 8 group letter
- 3 group letter
- Planned Parenthood Affiliates of California, Inc – Ann Marie Benitez
- California Primary Care Association - Molly Brassil
- ACCESS/Women's Health Rights Coalition – Destiny Lopez
- LA Best Babies Network – Carolina Reyes
- 15-Day group letter

Oral Comment
- Maternal and Child Health Access – Lucy Quacinella

Comment: Comments were made that the proposed regulations title were misleading as the Notice of Proposed Rulemaking and descriptive title did not reflect the elimination of the existing 20-day prior notice of termination and should be redrafted.

Response: MRMIB followed all notice requirements applicable to these regulations. Among other protocols, MRMIB informed the public of the changes that were being made by using "plain, straightforward language, avoiding technical terms as much as possible, using a coherent and easily readable style." (Government Code Section 11346.2 (a)(1).) In addition, MRMIB used the "strikeout to indicate deletion from the regulations." (Government Code Section 11346.2 (a)(3).) Furthermore, MRMIB provided the Initial Statement of Reasons, which includes the deletion of the 20 day prior notice language and a description of necessity as outlined in Government Code Section 11346.2 (b)(1). Per Government Code Section 11346.5 (c), "This section shall not be construed in any manner that results in the invalidation of a regulation because of the alleged inadequacy of the notice content." Therefore, MRMIB is rejecting this comment.

2) The comment immediately below was received by:

Written Comment
- 8 group letter
- 3 group letter
- Planned Parenthood Affiliates of California, Inc – Ann Marie Benitez
- California Primary Care Association - Molly Brassil
- ACCESS/Women's Health Rights Coalition – Destiny Lopez
- LA Best Babies Network – Carolina Reyes
- 15-Day group letter

Oral Comment

- Maternal and Child Health Access – Lucy Quacinella
- Planned Parenthood Affiliates of California, Inc – Ann Marie Benitez

Comment: Comments were received requesting that MRMIB not delete the 20-day notice reflected in Subsection 2699.209 (b) as the deletion allegedly violated due process and fairness, referencing federal regulations.

Sub-Comment (a): Commenters noted that removing the 20-day notice did not provide sufficient time for subscribers to disagree with being disenrolled due to fraud or failure to meet the residency requirement.

Sub-Response (a): MRMIB revised Subsection 2699.207 (d) and Subsection (e) to reflect that the program must provide notification to the subscriber on or before the 10th of the month for a disenrollment to occur at the end of that month; otherwise, disenrollment will occur the following month. MRMIB has added this clarification to provide prior notice of the determination made by the program that the subscriber has committed an act of fraud or fails to meet the residency requirement. Therefore, MRMIB accepts the recommendation in the comment regarding the 20-day notice, insofar as it addresses subscribers disenrolled for fraud or for failure to meet the residency requirement.

Sub-Comment (b): Commenters stated that the date a pregnancy ends through miscarriage may be a question of medical fact and that a 20-day notice is necessary to provide a subscriber timely notification of disenrollment and time to dispute the pregnancy end date.

Sub-Response (b): The statute directs MRMIB that "[a]t a minimum, coverage shall be provided to subscribers during one pregnancy, and for 60 days thereafter." (Insurance Code Section 12698.30.) As implemented, the program provides the baseline coverage described in the statute, and the program has been funded accordingly. Substantive eligibility ends on the 61st day following the end of a pregnancy. Furthermore, it is not accurate that women whose pregnancies end do not have prior notice that their coverage will end, since the AIM program informs applicants and subscribers in published materials, the AIM website, and correspondence to the subscriber that coverage is for one pregnancy and sixty days thereafter; this makes it clear that coverage ends 60 days after the end of the pregnancy. The AIM program does not have direct knowledge of the end date of a subscriber's pregnancy. Notice from the AIM program is contingent upon timely notification of the end of pregnancy being received by the AIM program. However, the AIM program does not have ability to ensure that subscribers provide timely notification of when all pregnancies end. In addition, a regulation is not required for an administrative practice providing for notification when timely notice from the subscriber is received. Furthermore, in response to this comment, MRMIB has clarified Subsection 2699.209 (b) to state

that the subscriber must notify the AIM program of the date the pregnancy ends by the 30th day after the pregnancy ends.

Therefore, since the pregnancy end date is known to the subscriber and not the program, MRMIB is rejecting this comment, but has incorporated language clarifying Subsection 2699.209 (b) in a supplemental Notice of Proposed Rulemaking (15-day notice) issued June 4, 2008.

Sub-Comment (c): Commenters stated that a subscriber whose eligibility ends because she gives birth at the end of a full term pregnancy should receive a 20-day disenrollment notice to allow time to plan for the end of coverage.

Sub-Response (c): See Sub-Response 2 (b). The AIM program does not distinguish between a full term pregnancy and a miscarriage for purposes of disenrollment. As described in Sub-Response 2 (b), MRMIB is rejecting this comment.

Sub-Comment (d): Commenters stated that women who miscarry before their effective dates of coverage should also be entitled to the 20-day notice of termination.

Sub-Response (d): A subscriber who is no longer pregnant on her effective date is not eligible for the AIM program under current regulations. Eligibility for AIM is not the subject of the proposed regulations. Therefore, MRMIB is rejecting this comment.

3) The comment immediately below was received by:

Written Comment
- 3 group letter
- Planned Parenthood Affiliates of California, Inc – Ann Marie Benitez
- California Primary Care Association - Molly Brassil
- ACCESS/Women's Health Rights Coalition – Destiny Lopez
- LA Best Babies Network – Carolina Reyes

Oral Comment
- Planned Parenthood Affiliates of California, Inc – Ann Marie Benitez

Comment: A comment was made requesting that the program reduce the subscriber contribution for all women who have a miscarriage, regardless of the stage in pregnancy. Commenters noted that the exact cut-off date between first and second trimesters can be imprecise. Commenters also noted the high rate of complications associated with later term pregnancies.

Response: The AIM program statute and regulations do not determine subscriber contribution amount based on cost of services or utilization of

services. The subscriber contribution amount is a standard amount determined by MRMIB, currently 1.5% of income, and by statute no greater than 2% of income. (Insurance Code Section 12696.05 (d)(1).) However, on a policy basis, MRMIB is reducing the subscriber contribution for first trimester miscarriages. This reduction is less appropriate later in pregnancy, when, as commenters note, the level of medical care may be more comparable to that of a full-term pregnancy. Concerning the suggestion that the cut-off date between trimesters can be imprecise, MRMIB notes that the definition of "first trimester" included in these regulations permits calculation based on either the number of weeks from the first day of a pregnant woman's last menstrual period or the first 13 weeks of a full-term pregnancy as documented by a licensed health care professional. Thus, the regulations take individual variances in the dates of the first trimester into account. Therefore, MRMIB rejects the comment.

4) The comment immediately below was received by:

Written Comment
- 8 group letter
- Asian Law Alliance – Jacquelyn K. Maruhashi

Oral Comment
- Maternal and Child Health Access – Lucy Quacinella

Comment: A comment was made requesting the program to reduce the subscriber contribution for women who have a miscarriage in the second trimester. The comment noted that the exact cut-off date between first and second trimesters can be imprecise.

Response: As stated in Response to Comment 3 and as further discussed there, at this time MRMIB has, on a policy basis, agreed only to reduce the subscriber contribution for women whose pregnancies end during the first trimester. Therefore, MRMIB rejects the comment.

5) The comment immediately below was received by:

Written Comment
- 8 group letter
- 15-Day group letter

Oral Comment
- Maternal and Child Health Access – Lucy Quacinella

Comment: A comment was made recommending that the AIM program conduct case reviews after the expected due date and before the 60th day following the due date. The comment also noted that this recommendation is an alternative that must be considered under the Administrative Procedures Act.

Response: This comment is not a reasonable alternative to the regulations, so it need not be considered as a prerequisite to adoption of these regulations. Specifically, this comment recommended that the program contact the subscriber in an effort to ensure that the program receives timely notification of the end of the pregnancy. This does not ensure that the program will in fact receive this information from the subscriber and does not mitigate the subscriber's responsibility to notify the program of the end of pregnancy. By statute, coverage is only for the enrolled pregnancy and 60 days thereafter. (Insurance Code Section 12698.30.) Furthermore, while MRMIB may consider recommendations on administrative practices to ensure timely receipt of information concerning the end date of subscribers' pregnancies, such changes need not be enacted in regulations. Finally, the comment does not accurately describe MRMIB's current administrative practices in all particulars; however, MRMIB's administrative practices are not the subject of the regulation package so MRMIB is not responding in a more detailed manner, here or in response to comments 6 and 7. Therefore, MRMIB is rejecting the comment.

6) The comment immediately below was received by:

Written Comment
- 8 group letter
- 15-Day group letter

Oral Comment
- Maternal and Child Health Access – Lucy Quacinella

Comment: A comment was made proposing that, as an alternative to conducting case reviews before the 60th day following the subscriber's expected due date, per comment number 5 , AIM can conduct reviews 120 days after the woman's estimated due date.

Response: As stated in Response 5, and for the reasons stated there, this is not a reasonable alternative to the proposed regulations and need not be considered in conjunction with the adoption of these regulations. Furthermore, these comments were made regarding administrative practices; while MRMIB may consider recommendations on administrative practices to ensure timely receipt of information concerning the end date of subscribers' pregnancies, such changes need not be enacted in regulations. Therefore, MRMIB is rejecting the comment.

7) The comment immediately below was received by:

Written Comment
- 8 group letter

- 15-Day group letter

Oral Comment
- Maternal and Child Health Access – Lucy Quacinella

Comment: A comment was made that, as an alternative to conducting case reviews at the eleventh month from the date of application (the date the Commenters stated that MRMIB conducts case reviews), the program should conduct reviews based on the estimated due date and not the application date.

Response: As stated in Response 5, this comment is not a reasonable alternative to the regulations, so it need not be considered as a prerequisite to adoption of these regulations. Furthermore, these comments were made regarding administrative practices that do not require modification of the program regulations. Therefore, MRMIB is rejecting the comment.

8) The comment immediately below was received by:

Written Comment
- 8 group letter
- 3 group letter
- ACCESS/Women's Health Rights Coalition – Destiny Lopez
- LA Best Babies Network – Carolina Reyes
- California Primary Care Association - Molly Brassil
- Planned Parenthood Affiliates of California, Inc – Ann Marie Benitez

Oral Comment
- Maternal and Child Health Access – Lucy Quacinella

Comment: A comment was made that the end dates of pregnancies caused by miscarriage are not entirely clear; some may begin one day and end on another day and this may cause complex issues of medical fact.

Response: The AIM program does not determine the day a pregnancy ends. MRMIB has clarified that it is the subscriber's obligation to notify the program within 30 days of when her pregnancy ends. Subsection 2699.207 (a)(2)(D) requires documentation by a licensed or certified healthcare professional indicating the date the pregnancy ended for purposes of receiving the subscriber contribution discount following a miscarriage. The regulations do not preclude documentation of a pregnancy end date by the subscriber's provider. Therefore, MRMIB is rejecting the comment.

9) The comment immediately below was received by:

Written comment
- Asian Law Alliance – Jacquelyn K. Maruhashi

- 15-Day group letter

Comment: A comment was made requesting that MRMIB not delete Subsection 2699.207 (b) and that notices need to be provided in the appropriate language and state the disenrollment, the effective date and the reason why AIM is terminating.

Response: MRMIB did not delete Subsection 2699.207 (b). This Subsection was rewritten to provide clarity by itemizing the information provided in the notice. The comment concerning availability of AIM notices in different languages does not address the subject of these regulations, but it is the case that the program provides written material in various languages based on enrollment levels in the AIM program. Therefore, MRMIB is rejecting the comment.

10) The comment immediately below was received by:

Written comment
- Asian Law Alliance – Jacquelyn K. Maruhashi
- 15-Day group letter

Comment: A comment was made that the deletion of Subsection 2699.207 (b) does not give the subscriber the opportunity to appeal the decision.

Response: This regulation package did not add, amend, or delete the appeal rights within the program. Therefore, MRMIB is rejecting the comment.

11) The comment immediately below was received by:

Written Comment
- 8 group letter
- 3 group letter
- California Primary Care Association - Molly Brassil
- LA Best Babies Network - Caroline Reyes
- ACCESS/Women's Health Rights Coalition – Destiny Lopez
- Asian Law Alliance – Jacquelyn K. Maruhashi
- Planned Parenthood Affiliates of California, Inc – Ann Marie Benitez

Oral Comment
- Maternal and Child Health Access – Lucy Quacinella
- Planned Parenthood Affiliates of California, Inc – Ann Marie Benitez

Comment: Commenters stated that they supported the subscriber contribution reduction for first trimester miscarriages.

Response: MRMIB is accepting the comment.

12) The comment immediately below was received by:

Written Comment
- Asian Law Alliance – Jacquelyn K. Maruhashi
- 15-Day group letter

Comment: Commenters supported the addition of Subsection 2699.207 with a recommendation to modify the language to require that the HMO or healthcare provider contact AIM regarding the miscarriage.

Response: The AIM regulations have been amended to clearly identify that it is the subscriber's obligation to notify AIM. The acceptance of information from the health plan or providers can be administratively considered but is not an appropriate regulatory requirement. MRMIB does not have regulatory authority over providers and embodies its agreements with health plans in contracts. Therefore, MRMIB is rejecting the comment.

13) The comment immediately below was received by:

Written Comment
- ACCESS/Women's Health Rights Coalition – Destiny Lopez
- California Primary Care Association - Molly Brassil

Comment: A comment was made that the AIM materials should instruct women to contact the AIM Program as soon as they have a miscarriage or the Healthy Families Program as soon as the baby is born.

Response: This comment addresses administrative notices and is not directed at the proposed regulations. Therefore, MRMIB is rejecting the comment.

14) The comment immediately below was received by:

Written Comment
- 8 group letter

Oral Comment
- Maternal and Child Health Access – Lucy Quacinella

Comment: Commenters stated that excluding second trimester miscarriages violates the consistency requirement.

Response: It is unclear to MRMIB what the basis is for this comment. The comment does not demonstrate that reduction of subscriber premiums for first trimester miscarriages is inconsistent with applicable law. Therefore, MRMIB rejects this comment.

15) The comment immediately below was received by:

Written Comment
- 8 group letter

Comment: Commenters stated that the proposed regulations failed to meet the necessity standard.

Response: It is unclear to MRMIB what the basis is for this comment. Necessity under the definition provided in Government Code 11349 has been demonstrated in the Initial Statement of Reasons, where each change has been described, along with the purpose of the change. Therefore, MRMIB rejects this comment.

Starting with number 16, the comments listed were raised for the first time in a letter ("15-Day group letter") responding to the June 4, 2008, 15-day notice proposing modification of the original Notice of Proposed Rulemaking issued April 18, 2008. In addition, the "15-Day group letter" reiterated comments submitted earlier; therefore, this letter also is noted as a source for some of the comments listed above.

16) The comment immediately below was received by:

Written comment
- 15-Day group letter

Comment: Commenters stated that appeals should to be reviewed by an impartial adjudicator and not addressed to the Executive Director.

Response: This regulation package did not add, amend, or delete the appeal rights within the program. Furthermore, this is not an issue addressed in the June 4, 2008, modified regulation package. Therefore, MRMIB is rejecting the comment.

17) The comment immediately below was received by:

Written comment
- 15-Day group letter

Comment: Commenters stated that the amended Subsection 2699.209(b) from the June 4, 2008 revised regulations was not sufficiently related to the original proposed regulations.

Response: As stated in Sub-Response 2(b), the amended section was added to provide clarity that the subscriber must notify the AIM program of the pregnancy end date. This change is part and parcel of the provision in the original Notice of Proposed Rulemaking that coverage ends on the 61st day

following the end of pregnancy; the additional change is responsive to previous comments objecting to terminating coverage on the 61st day because the commenters allege that, in some cases, this may not provide prior notice. Furthermore, as summarized in Comments 2 and 8, commenters stated that the end date of pregnancy may be in dispute. This additional clarification to the regulations states that the subscriber must notify the program of the end date, thus minimizing the likelihood of dispute concerning the date. As this change is sufficiently related, MRMIB is rejecting the comment.

18) The comment immediately below was received by:

Written comment
- 15-Day group letter

Comment: Comments were received recommending that subscribers should continue to receive the same benefits pending appeal.

Response: This regulation package did not add, amend, or delete the appeal rights within the program. Furthermore, this is not an issue addressed in the June 4, 2008, modified regulation package. Therefore, MRMIB is rejecting the comment.

19) The comment immediately below was received by:

Written comment
- 15-Day group letter

Comment: Comments were received recommending that the notice of disenrollment should explain the appeal process.

Response: The June 4, 2008, modified regulation package did not amend the disenrollment notice. In addition, Subsection 2699.207 (b)(3) does require the notice to explain the appeal process. Therefore, MRMIB is rejecting the comment.

20) The comment immediately below was received by:

Written comment
- 15-Day group letter

Comment: Commenters stated that the subscriber's obligation to report the end of pregnancy goes and beyond the description of the original rule-making package.

Response: As described in Response 17, the modification is sufficiently related. Therefore, MRMIB is rejecting this comment.

21) The comment immediately below was received by:

Written comment
- 15-Day group letter

Comment: Comments were made that the modification of Subsection 2699.209(b) does not comply with the Administrative Procedures Act as the regulation does not define reporting or notification.

Response: The modified text of Subsection 2699.209 (b) does not limit the various ways subscribers may notify the program that pregnancy has ended. As this benefits subscribers by allowing all reporting and notification avenues, MRMIB is rejecting the comment.

22) The comment immediately below was received by:

Written comment
- 15-Day group letter

Comment: Commenters stated that the regulations needed to clarify that notification may be given by others with the woman's permission.

Response: As described in Response 21, the regulations do not limit the ways a woman may notify the AIM program, including giving someone else permission to notify the AIM program. Therefore, MRMIB is rejecting the comment.

23) The comment immediately below was received by:

Written comment
- 15-Day group letter

Comment: Commenters requested that the regulations should define that notification requirements are based on the post-mark from the U.S. mail.

Response: The regulations do not limit the subscriber's options for providing notification to the AIM program. Therefore, MRMIB is rejecting the comment.

24) The comment immediately below was received by:

Written comment
- 15-Day group letter

Comment: Commenters suggested adding a regulatory requirement to clarify that women, who do notify AIM timely, will receive a 20-day notice of disenrollment.

Response: As described in Sub-Response 2(b), a regulation is not required for an administrative practice providing additional prior notice of disenrollment when the AIM program receives timely notification. As Sub-Response 2(b) outlines, the AIM program provides information that coverage will end 60 days after the end of the pregnancy in published material, the AIM website, and correspondence to the subscriber. MRMIB can consider additional notices to subscribers without a regulatory requirement. Therefore, MRMIB is rejecting this comment.

25) The comment immediately below was received by:

Written comment
- 15-Day group letter

Comment: A comment was made recommending that the AIM program conduct case reviews after the 31st expected due date for women who do not notify the AIM program of the end of pregnancy.

Response: As stated in Responses 5, 6, and 7, this is not a reasonable alternative to the proposed regulations and need not be considered in conjunction with the adoption of these regulations. Furthermore, these comments were made regarding administrative practices that do not require modification of the program regulations. Therefore, MRMIB is rejecting the comment.

26) The comment immediately below was received by:

Written comment
- 15-Day group letter

Comment: Commenters requested an exception from the 30-day reporting requirement for women who miscarry.

Response: As outlined in Response 22, the regulations do not preclude any means of notifying the program, including through a designated representative. As also addressed in Sub-Response 2(b), substantive eligibility ends on the 61st day following the end of a pregnancy. Therefore, MRMIB is rejecting this comment.

27) The comment immediately below was received by:

Written comment
- 15-Day group letter

Comment: A comment was received requesting AIM to cover medical services received by women who miscarry beyond the 60th day of coverage.

Response: The scope of coverage in the program is not the subject of these regulations. The AIM regulations, consistent with statute, provide that coverage is for one pregnancy and 60 days thereafter. (Insurance Code Section 12698.30.) Therefore, MRMIB is rejecting this comment.

28) The comment immediately below was received by:

Written comment
- 15-Day group letter

Comment: Commenters alleged that the text of the regulation tacitly admits a prior underground regulation.

Response: MRMIB disagrees with the allegation; however, this is not a comment on the proposed regulations. Therefore, MRMIB is rejecting this comment.

29) The comment immediately below was received by:

Written comment
- 15-Day group letter

Comment: A comment was received requesting that AIM cover medical services beyond the 60th day of coverage for women who miscarry.

Response: The scope of coverage in the program is not the subject of these regulations. The AIM regulations, consistent with statute, provide that coverage is for one enrolled pregnancy and 60 days thereafter. (Insurance Code Section 12698.30.) Therefore, MRMIB is rejecting this comment.

30) The comment immediately below was received by:

Written comment
- 15-Day group letter

Comment: Commenters requested that the plans and providers be required to report on miscarriages, since the AIM program has proposed increasing the average annual plan capitation rate.

Response: As stated in Response 15, MRMIB does not have regulatory authority over providers and embodies its agreements with health plans in contracts. Furthermore, this is not an issue addressed in the June 4, 2008, modified regulation package. Therefore, MRMIB is rejecting the comment.

CPCA
California Primary
Care Association

Health Care Access for All

June 2nd, 2008

Managed Risk Medical Insurance Board
Attn: JoAnne French
1000 G Street, Suite 450
Sacramento, CA 95814

Re: CPCA Comments to Notice of Proposed Rulemaking R-2-08, *Proposed AIM Reduced Subscriber Contributions Following First Trimester Miscarriage*

Dear Ms. French:

The California Primary Care Association (CPCA) represents over 650 not-for-profit community clinics and health centers that provide comprehensive primary health care services to more than 3.5 million low-income, ethnically diverse patients of which half are limited English proficient and over 80% have incomes under 200% of the federal poverty level. CPCA provides a vast array of primary care services including comprehensive prenatal care and other women's health and family planning services. CPCA strongly promotes efficient, timely access to cost-effective preventive and other essential health care in order to best support the health of women and children.

CPCA would like to extend appreciation to the Managed Risk Medical Insurance Board (MRMIB) for the action taken to provide a rebate to those women who miscarry in the first trimester of their pregnancy and are able to inform Access for Infants and Mothers (AIM) of their miscarriage. The ability for women to avoid a painful reminder of their loss in the form of continued billing is an important policy that we hope the AIM program will maintain.

While we appreciate the current policy, CPCA strongly urges MRMIB to extend this policy to *all* women who miscarry, regardless of the stage in pregnancy. In addition to the often arbitrary nature of trimesters, later miscarriages are often exceedingly traumatic to women who have had a longer period of time with their pregnancies and continuing to bill women for their pregnancy-related coverage poses to exacerbate an already difficult time.

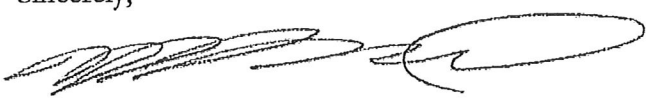
Additionally, these regulations address a second issue not reflected in the title: the elimination of the existing 20-day prior notice of termination of AIM benefits and health plan coverage. It is critical that prior notice be given to all AIM beneficiaries women before

a termination of coverage. It is critical that materials provided by AIM clearly instruct beneficiaries to contact the AIM program as soon as they have miscarried or the Healthy Families program as soon as a baby is born. If women are not made aware that their health coverage is about to end, they may be in danger of incurring significant medical bills under false assumptions about their benefits and/or coverage.

CPCA urges MRMIB to continue to provide the 20-day prior notice to women of the termination of their AIM program benefits and health plan coverage. CPCA also strongly urges MRMIB to extend the rebate policy to *all* women who miscarry, regardless of the stage in pregnancy.

CPCA welcomes your feedback to the comments outlined in this letter. Please do not hesitate to contact us with any questions or concerns.

Sincerely,



Molly Brassil, MSW
Associate Director of Policy

Comment 2
R-2-08 , 45-Day Comment Period

Maternal and Child Health Access

1111 W. Sixth Street, Suite 400
Los Angeles, CA 90017-1800
Tel 213. 749. 4261
Fax 213. 745. 1040
www.mchaccess.org

June 3, 2008

Managed Risk Medical Insurance Board
Attn: JoAnne French
1000 G Street, Suite 450
Sacramento, CA 95814
jfrench@mrmib.ca.gov
FAX (916) 327-6580

Re: Notice of Proposed Rulemaking R-2-08, *Proposed AIM Reduced Subscriber Contributions Following First Trimester Miscarriage*

Dear Ms. French:

Attached please find the comments of organizations listed below on R-2-08.

Sincerely,

Maternal and Child Health Access
Lynn Kersey, MA, MPH
Executive Director
1111 W. Sixth St. Fourth Fl.
Los Angeles, CA. 90017

Lucy Quacinella, Esq.
Multiforum Advocacy Solutions
275 Fifth St., Suite 416
San Francisco, CA. 94103

American College of Obstetricians and Gynecologists - District IX
Shannon Smith-Crowley, J.D., M.H.A.
Legislative Advocate
1425 River Park Drive, Suite 235
Sacramento CA 95815

California Medical Association
David Ford
Associate Director, Medical and Regulatory Policy
1201 J Street
Sacramento, CA 95814

Center for Public Interest Law
Children's Advocacy Institute
Robert Fellmeth, Esq.
University of San Diego
5998 Alcala Park
San Diego, CA. 92110

LA Best Babies Network
Carolina Reyes, MD
Executive Director
350 South Bixel St. Suite 100
Los Angeles, CA 90017

Planned Parenthood Affiliates of California
Lilly Spitz, Chief Legal Counsel
555 Capitol Mall, Suite 510
Sacramento, CA 95814

Barbara Rice, PHN
Health Services Manager
Health Services Agency
1060 Emeline Ave.,
Santa Cruz, CA 95061

Encs.

Summary of Concerns

1) In excluding women who miscarry during the second trimester of pregnancy from AIM's proposed new subscriber contribution reduction rule, the proposed regulations fail to meet the necessity standard of the Administrative Procedures Act (APA).

2) The descriptive title for R-2-08 and Initial Statement of Reasons fail to explain that AIM proposes to repeal the long-standing regulation requiring that women be given at least 20-days notice before their AIM benefits are terminated and their health plan coverage ends. This filing, therefore, fails to meet the APA's notice of rulemaking requirements.

3) Repealing the 20-day prior notice rule from existing § 2699.209(b) conflicts with due process. R-2-08 therefore fails to meet the APA's consistency standard.

4) R-2-08 fails to meet the APA's requirement that agencies consider an appropriate range of reasonable alternatives, including those that would lessen impacts on small businesses and on individuals.

Background

- The AIM Program
- The State Children's Health Insurance Program
- Due Process Under the State and Federal Constitutions

Notice and opportunity to be heard when AIM benefits are terminated and a woman is disenrolled from her health plan

- What can lead to termination of AIM benefits and health plan disenrollment?
- What information must be included in a notice to terminate AIM benefits and disenroll a woman from her health plan?
- When do the termination of AIM benefits and plan disenrollment take effect?
- Must notice be given *before* the termination of AIM benefits and disenrollment from the health plan take effect?

The consequences of retroactive termination of AIM benefits and health plan disenrollment

- Because the repeal of AIM's 20-day prior notice rule conflicts with due process, R-2-08 fails to meet the APA's consistency standard.

Summary of Concerns

1) **In excluding women who miscarry during the second trimester of pregnancy from AIM's proposed new subscriber contribution reduction rule, the proposed regulations fail to meet the necessity standard of the Administrative Procedures Act (APA).**

The proposed regulations are in part about the Access for Infants and Mothers (AIM) "subscriber contribution" reduction for women who miscarry in the first trimester. Maternal and Child Health Access (MCHA) supports this, but the exclusion of women in the second trimester from similar relief is arbitrary, especially since the exact cut-off date between the first and second trimesters can be imprecise. R-2-08, therefore, fails to meet the APA's necessity standard for rulemaking, set forth in Government Code § 11349(a).

2) **The descriptive title for R-2-08 and Initial Statement of Reasons fail to explain that AIM proposes to repeal the long-standing regulation requiring that women be given at least 20-days notice before their AIM benefits are terminated and their health plan coverage ends. This filing, therefore, fails to meet the APA's notice of rulemaking requirements.**

The proposed regulations do far more than provide for "reduced subscriber contributions following first trimester miscarriage", an issue that may affect fewer than 60 women with AIM each year. The proposed amendment to § 2699.209(b) would repeal the long-standing regulation requiring the AIM program to give women at least 20-days' prior notice before terminating their benefits and disenrolling them from their health plans, to the detriment of *all* the women in the AIM program, about 11,500 a year. Given the narrowly focused title and the incomplete description in the Initial Statement of Reasons, R-2-08 is inadequate under the notice of rulemaking requirements of Government Code §§ 11346.2(b) and 11346.5(a)(3)(A)-(C).

3) **Repealing the 20-day prior notice rule from existing § 2699.209(b) conflicts with due process. R-2-08 therefore fails to meet the APA's consistency standard.**

R-2-08 fails to meet the standard of Government Code § 11349(d) because the proposed regulations are inconsistent with due process.

As noted, R-2-08 includes the repeal of the existing requirement that the AIM program provide women with at least 20-days notice of termination before AIM eligibility and health insurance benefits end (proposed amendment to § 2699.209(b)).

- Due process requires that the rule requiring a minimum of 20-days prior notice be retained for *all* women with AIM. This is important for many reasons:

  - **To avoid confusion:** AIM keeps billing women monthly over 12 months and obliges them to pay, *even after their pregnancies end.* This is very confusing, and most women believe, quite reasonably, that they continue to have health insurance as long as they keep making their AIM payments on time each month. Confusion is especially a problem for women with post-partum depression, which can be a major debilitating factor, especially after a miscarriage (see Attachments A-C). Prior notice of health plan disenrollment at least helps inform a woman that she is about to become uninsured, even though her monthly AIM bills will continue.

  - **To give lead time to prepare:** Women need precise prior notice of the exact date their health insurance coverage is to end so that they can prepare and act accordingly--for example, by not scheduling medical appointments that would otherwise take place after the termination date--in order to avoid medical debt when they become uninsured.

  - **To give women who miscarry, and their doctors, a chance to clarify the dates on which the miscarriage and 60th day post-partum occur:** AIM's 60-day post-partum coverage period is triggered by the end of the pregnancy. But when there's been a miscarriage, the exact day that a pregnancy ends is not always clear and may involve complex issues of medical fact. Similarly, establishing the day on which the first trimester ended may also be a question of fact.

  - **To give women an opportunity to challenge erroneous allegations about lack of eligibility:** The AIM program retroactively disenrolls women not just after the pregnancy has ended, but also if the program believes that the woman is not a California resident. In addition, AIM retroactively disenrolls if it believes that a woman has committed fraud. Where facts such as these may be in dispute, women must be given an opportunity to present their side of the story before being disenrolled.

  - **To be fair to women who the AIM program has determined are eligible and who are issued AIM health plan cards but whose pregnancies end before the technical "effective date of coverage" begins:** At present, the AIM program treats women in this situation as if they've never been found eligible at all and provides no coverage whatsoever, not even for the miscarriage itself or any follow-up care during the 60-day post-partum period. A woman in this tragic situation deserves at least 20-days prior notice before being disenrolled from her health plan.

4) R-2-08 fails to meet the APA's requirement that agencies consider an appropriate range of reasonable alternatives, including those that would lessen impacts on small businesses and on individuals.

R-2-08 fails to meet the requirement set forth in Government Code §§ 11346.2(b)(3)(A) and (B) and 11346.3(a) that agencies consider reasonable alternatives to their proposed regulations, especially alternatives that would lessen impacts on small businesses and individuals. Affected parties here are physicians and community health clinics with AIM patients, small businesses that cannot afford health insurance coverage for pregnant employees, and working poor women who would be disenrolled without prior notice under these proposed regulations.

There are many reasonable alternatives to the proposed repeal of AIM's existing 20-day prior notice requirement. While the AIM program has considered and rejected some alternatives (these are not described here), other important alternatives have not yet been considered to our knowledge. The two most important ones are:

a) The AIM program should conduct program reviews more frequently than eleven months following a woman's AIM application date; the reviews should instead be linked to the woman's expected due date and be conducted by AIM well *before* the end of her anticipated 60-day post-partum coverage period.

AIM eligibility lasts until the 60th day post-partum. As part of the AIM application process, women give AIM their expected due dates. Instead of waiting until the eleventh month after a woman applies to AIM to contact her health plan, as the program does now, AIM could contact the plans shortly after the woman's expected due date (for example, from 10 to 30 days following the woman's expected due date) if she hasn't already enrolled her newborn into Healthy Families or reported a miscarriage directly to AIM, and then issue the 20-day prior notice of termination and disenrollment accordingly, before the end of the 60-day post-partum coverage period.

- As noted, under this alternative, the 20-day prior notice of termination would fit in well with the end of AIM coverage on the 60th day post-partum.

- AIM may point out, however, that reviewing cases shortly after the expected due date is "too early", since a woman with AIM has until the infant's first birthday to enroll the child into Healthy Families, and, when the child is enrolled, AIM will find out that the pregnancy has ended. In addition, this approach might require more than one contact to the health plan by AIM, since the woman may not have delivered by the time of her original estimated due date.

- But in the spirit of reaching a just and equitable solution to avoid the extreme harms that can flow from plan disenrollment without prior notice, this alternative should be given serious consideration: a little more administrative burden on AIM to comply with due process and spare women from bankrupting medical debt is reasonable.

b) A different alternative would be for AIM to conduct reviews 120 days after the woman's estimated due date instead of eleven months after her application date.

If AIM believes that it is too burdensome to conduct case reviews shortly after the estimated due date, then, where a woman has not reported to either Healthy Families or AIM by the 60th day after her estimated due date, AIM should conduct its review with the health plan in another 60 days (i.e., 120 days after the estimated due date), instead of waiting, as AIM does now, until the eleventh month after the date a woman applies for AIM to review her case. The woman's full subscriber contribution obligation would remain intact for the additional 60 days, regardless of whether she miscarried during the first trimester.

- Again, the 20-day prior notice of termination requirement would be retained, and its timing would fit well here.

- The additional 60 days gives ample leeway for AIM case reviews where the estimate for a woman's due date was too early; in addition, more women can be expected to have reported their newborns to Healthy Families by the timeframe of this alternative.

- It is reasonable to believe that few women would require AIM case reviews under this alternative. The AIM program has recently indicated that it is committed to implementing improved methods for informing AIM enrollees, advocates, and providers that AIM places the duty to quickly report the end of a pregnancy, whether by miscarriage or a live birth, on the woman. If better communication from AIM occurs, it is likely that more women will report the end of their pregnancies more quickly to AIM, especially if the information is translated into all the necessary languages..

Background

- **The AIM Program**

AIM provides comprehensive health benefits through managed care plans to eligible low-income pregnant women with countable family income from 201% to 300% of the federal poverty level.[1]

Eligibility for AIM lasts through the pregnancy and for 60 days post-partum. § 2699.209(b). The women receive their health care from managed care plans.

To participate in AIM, a woman must pay 1.5% of her gross annual family income to the program in "subscriber contributions". Women are billed each month by AIM for this amount over a twelve-month period (unless a woman opts to pay the total annual amount she owes up front or to make more frequent installment payments). The monthly billing continues for the full twelve months, even after the woman's 60-day post-partum period is over and she is no longer eligible to use health plan services.

AIM applications take up to ten days to process (§ 2699.203(b)); if a woman is approved for AIM, her effective date of coverage in a health plan starts within ten days after AIM has found her eligible (§ 2699.209(a)). But if the woman is no longer pregnant on what would have been her effective date of health plan coverage, she gets no coverage at all. *Id.*

- **The State Children's Health Insurance Program**

AIM is funded in part through the federal State Children's Health Insurance Program (S-CHIP). Under S-CHIP, AIM must give participants adequate prior notice and opportunity to be heard before benefits end; during an appeal, AIM benefits must continue. Title 42, Code of Federal Regulations (C.F.R.), §§ 457.1120(a)(1), 457.1130(a)(3), 457.1140, 457.1150(a), 457.1160(a), 457.1170, and 457.1180.

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[1] The AIM statutes are at Insurance Code §§ 12695 *et seq.*, and the regulations are at Title 10, California Code of Regulations (CCR), §§ 2699.100 *et seq.* All references in this document are to Title 10 of the Code of Regulations unless otherwise indicated.

- **Due Process Under The State and Federal Constitutions**

State benefits programs like AIM must also comply with due process requirements under both the California and United States Constitutions. These requirements include adequate notice and opportunity to be heard. *See, e.g., Goldberg v. Kelly* (1970) 397 U.S. 254.

- **Notice and opportunity to be heard when AIM benefits are terminated and a woman is disenrolled from her health plan**

    - **What can lead to termination of AIM benefits and health plan disenrollment?**

Because women in AIM get their health care from managed care plans, it is important to note the connection between the termination of eligibility for AIM benefits on the one hand and the woman's disenrollment from her managed care health plan on the other. Under existing § 2699.207(a)(1) and (2), a woman loses her AIM benefits and "shall be disenrolled from [both] the program and from the program's participating health plan" if: (1) she asks to be disenrolled; or (2) she becomes ineligible.

Under existing § 2699.207(a) (2)(A)-(C), the reasons for ineligibility that can lead to both a woman's termination from AIM and disenrollment from her health plan are:

(A) The woman doesn't meet AIM's residency requirement;

(B) The woman has committed fraud; or

(C) The woman is no longer pregnant *on* her effective date of health plan coverage.

Significantly, the fourth and most common situation resulting in the loss of AIM eligibility, i.e., when the pregnancy has ended *after* the woman's effective date of health plan coverage, is discussed in a separate regulation, existing § 2699.209(b), addressed below.

- **What information must be included in a notice to terminate AIM benefits and disenroll a woman from her health plan?**

In each of the three situations in which termination of AIM benefits and plan disernollment is authorized under § 2699.207(a)(2)(A)-(C) (i.e., when it is alleged that the woman is not a California resident, or that she has committed fraud, or that she was no longer pregnant on her effective date of coverage), existing § 2699.207(b) clearly provides that the woman "shall be notified by the program in writing of the disenrollment . . .from the program, the effective date, and the reason for the disenrollment." Existing § 2699.207 is silent, however, as to whether the notice of disenrollment must explain the appeal process provided for under §§ 2699.500(b)(2), 2699.503(a). **R-2-08 resolves this ambiguity with the express requirement that the notice of disenrollment include an "explanation of the appeals process." (Proposed § 2699.207(b)(3)).**

As to the required contents of the notice when AIM benefits are terminating because the pregnancy ended *after* the woman's effective date of health plan coverage, a different regulation, existing § 2699.209(b), provides that the notice include only "the date [the subscriber's] coverage ends. . ." **R-2-08 would add the reason for the termination and an explanation of the appeals process (Proposed § 2699.207(a)(2)(D) and (b)(1)-(3)).**

- **When do the termination of AIM benefits and plan disenrollment take effect?**

The answer depends on the reason for the termination and disenrollment; as noted above, there are several possible reasons.

First, under existing § 2699.207(c), if the reason for disenrollment is that the woman herself requested it, the "disenrollment shall take effect at the end of the calendar month in which

the request was received or at the end of a future calendar month as requested by the applicant". **R-2-08 does not change this (Proposed § 2699.207(c)).**

Second, the same rule for the effective date for disenrollment applies under existing § 2699.207(c) when the reason involves an allegation that the woman does not have California residency or that she has committed fraud. It is difficult to see, however, how the rule on the effective date of disenrollment that is used in cases where the disenrollment is being done at the woman's request could be used here, since, by definition, there is no "request" from the woman to have herself disenrolled when others allege that she is not a state resident or that she has committed fraud; moreover, to allow the woman to choose a future calendar month for disenrollment would seem to negate AIM's authority to remove her from the program for lacking residency or having committed fraud. Thus, when the reason for disenrollment is alleged lack of residency or fraud, the existing regulations are ambiguous. **R-2-08 clarifies the ambiguity, by specifying that the disenrollment takes effect "at the end of the calendar month in which the program determines that the subscriber fails to meet the residency requirement. . .[or] has committed fraud" (Proposed § 2699.207(d) and (e)).**

Third, when the situation prompting disenrollment is that the woman was no longer pregnant *on* the effective date of coverage, existing § 2699.207(c) plainly states that disenrollment "shall take effect upon the date that would have been the effective date of coverage." This is consistent with the rule, in existing § 2699.209(a), that "[c]overage shall not begin if the pregnancy terminates prior to the effective date of coverage." **R-2-08 makes no changes here (Proposed § 2699.207(f)).**

Finally, with respect to the most common situation leading to termination of AIM benefits and plan disenrollment, i.e., when the woman's pregnancy ends *after* the effective date of

coverage, the effective date of the disenrollment is addressed in a separate regulation; that regulation is existing § 2699.209 (b), which equates "disenrollment" with "the end of coverage" and states:

> Coverage in the program for the subscriber shall be for one pregnancy and shall include services following the pregnancy for sixty (60) days. The subscriber shall be notified of the date her coverage ends and such notice will be provided *at least twenty (20) days prior to that date*. (Emphasis added).

Thus, disenrollment for women whose pregnancies end after the effective date of coverage can take effect only after the following two conditions have been met: (1) at least 60 days have passed since the end of the pregnancy; and (2) at least 20 days have passed since the AIM program gave the woman notice that her health plan coverage would be ending on a date certain. While these two time periods may run concurrently, legally no disenrollment can take effect until both time periods have elapsed. **R-2-08, however, would repeal the 20-day prior notice requirement and make the disenrollment effective on the 61st day after the end of the pregnancy (proposed amendment to § 2699.209(b); Proposed § 2699.207(a)(2)(D) and (g)). This creates major due process concerns, addressed further below.**

- **Must notice be given *before* the termination of AIM benefits and disenrollment from the health plan take effect?**

Whether the notice must be given before AIM benefits terminate and the woman is disenrolled from her health plan depends on the reason for the termination and disenrollment:

When the pregnancy ends *after* the effective date of coverage: When the reason for termination and disenrollment is that the pregnancy ended *after* the woman's effective date of health plan coverage, existing § 2699.209(b) makes it perfectly clear, as noted immediately above, that "[t]he subscriber shall be notified of the date her coverage ends and such notice will be provided at least twenty (20) days prior to that date." The existing regulation is thus consistent

with due process (42 C.F.R. §§ 457.1120(a)(1), 457.1130(a)(3), 457.1140, 457.1150(a), 457.1160(a), 457.1170, and 457.1180; *Goldberg v. Kelly,* (1970) 397 U.S. 254). **R-2-08, however, would repeal the 20-day prior notice rule (proposed amendment to § 2699.209(b)), allowing for disenrollment without any prior notice at all, creating major due process concerns.**

When the pregnancy ends *before* the effective date of coverage: As noted in the "Background" discussion above, a woman's health plan coverage may not start until ten days after the date that the AIM program determines she is eligible. Existing § 2699.209(a) provides that, even though a woman has been determined eligible for AIM by the program itself, her health plan "[c]overage shall not begin if the pregnancy terminates prior to the effective date of coverage." Thus, the prior notice requirement in subdivision (b) of the same existing § 2699.209 does not apply when the pregnancy ends before the effective date of coverage. **R-2-08 would not correct this gross injustice and due process violation for women who miscarry shortly AIM has determined they are eligible for benefits-- but it should.**

When the woman requests disenrollment: Under existing § 2699.207(a)(1)), when the woman herself requests disenrollment, the timing of the notice presumably depends on when the woman makes the request and whether she asks for the disenrollment to take effect at the end of some future calendar month. **R-2-08 retains this approach (Proposed § 2699.207(c)).**

When the woman is alleged to lack state residency or to have committed fraud: If AIM benefits and enrollment are ending because the woman is alleged to no longer be a California resident or to have committed fraud, existing § 2699.207 (a)(2)(A) and (B) and (b) do not address when the notice must be given. Clearly, where facts such as whether a woman is a California resident or whether she has committed fraud may be disputed by the woman herself,

she has a right to notice and an opportunity to be heard to present her side of the story before benefits may lawfully terminate or the disenrollment takes effect. Fortunately, the gap is filled in by existing § 2699.209(b), which provides for at least 20-days notice before AIM "coverage" ends. By construing the disenrollment "for cause" provisions of existing § 2699.207(a)(2)(A) and (B) and (b) along with the 20-day prior notice rule for the end of coverage in existing § 2699.209(b), the AIM program avoids what would otherwise be a major procedural due process violation in administration of the program. **R-2-08, however, would repeal the 20-day prior notice rule (proposed amendment to § 2699.209(b)), allowing for disenrollment without any prior notice at all when an AIM enrollee is alleged to lack state residency or to have committed fraud, creating major due process concerns.**

- **The consequences of retroactive termination of AIM benefits and health plan disenrollment**

The consequences of a retroactive disenollment from a woman's AIM health plan can be extremely severe, literally leading to bankruptcy over medical debt.

Until the notice of termination of AIM benefits and plan disenrollment is issued, an AIM subscriber continues to be billed each month by the AIM program for the amount of her monthly subscriber contribution. If the woman continues to pay on time each month, it is reasonable for her to assume that she continues to have AIM coverage, especially when her managed care health plan and doctors and other medical providers continue to provide her with medical care as a participant in the AIM program.

When AIM terminates her benefits and health plan enrollment effective retroactively and with notice only after the fact, the woman becomes responsible for all of the medical care received in the interim. Her health care providers may then pursue the woman for payment, at the high rates that are cost-shifted to private-pay uninsured persons and which are far more than

the AIM program or any other insurer would have to pay. Low-income working women and their families may face bankruptcy from these debts, or risk homelessness and hunger if they try to pay off their medical bills.

Such dire consequences can be avoided by providing women with sufficient prior notice and opportunity to be heard. The 20-day prior notice rule contained in existing § 2699.209(b) is thus critical to due process under AIM; its proposed repeal is a draconian change that would utterly thwart due process for all women who participate in AIM.

- **Because the repeal of AIM's 20-day prior notice rule would violate due process, R-2-08 fails to meet the APA's consistency standard.**

To be approved under Government Code §§ 11349 (d) and 11349.1(a)(6) of the APA, proposed state regulatory action must be consistent, that is, "in harmony with, and not in conflict with or contradictory to, existing. . .court decisions[] or other provisions of law". AIM enrollees are entitled to adequate prior notice and opportunity to be heard before their benefits end under 42 C.F.R. §§ 457.1120(a)(1), 457.1130(a)(3), 457.1140, 457.1150(a), 457.1160(a), 457.1170, and 457.1180 and *Goldberg v. Kelly* (1970) 397 U.S. 254. As the proposed repeal of the 20-day prior notice rule in § 2699.209(b) would be in conflict with these provisions of law, R-2-08 fails the APA's consistency test.

Being a California resident or committing fraud involves questions of fact. If the AIM program alleges that a woman is not a state resident or that she has committed fraud, the woman has a legal right to respond, contest the allegations, and present her version of the facts before an impartial adjudicator before her health benefits are terminated. Benefits must continue pending a decision on her appeal.

Questions of fact may also be involved even in AIM cases where eligibility ends due to a miscarriage. The date that a woman miscarries is not always clear, as the process may begin on

one day but not end until several days later. For a woman who does not report the occurrence of a miscarriage to AIM, the AIM program doesn't gather information about her case until the eleventh month after the woman's AIM application was approved, at which point AIM contacts only the health plan. But the health plan administrator will only glean information from records in the woman's insurance file. A woman has the right to challenge the date the AIM program uses to establish the end of her pregnancy. The stakes are very high, and even one day's difference can have dramatic consequences for the woman. For example, if AIM believes the date the pregnancy ended is as little as one day before the woman's effective date of coverage, she will receive no coverage at all, not even for the miscarriage or any post-partum care. And if AIM believes that, though the pregnancy did end after the effective date of coverage, the end came just one day into the woman's second trimester, the woman will miss out on the new reduction in subscriber contributions for first trimester miscarriages. In both types of cases, a woman who miscarries has a right to present AIM with proof from the obstetrician and others who treated her and who have personal knowledge of her health history and what happened and when; she also has the right to have her AIM benefits and plan enrollment continue pending the outcome of her appeal.

As to situations in which AIM eligibility will be ending as of the 61st day after the woman has delivered a healthy newborn, the woman has a due process right to notice that her benefits and coverage are about to end-- before they end-- and to know the exact date on which they will end, so that she can prepare to avoid incurring charges for medical services she cannot afford. Such notice, as provided for in the existing § 2699.209(b), is especially necessary in AIM in order to avoid the confusion that arises from the monthly bills that AIM continues to send women even after their pregnancies end: women reasonably believe they remain covered by

AIM as long as they pay their bills to AIM on time and their medical providers continue to see them as AIM patients with comprehensive health care coverage. Repeal of the 20-day prior notice rule in existing § 2699.209(b) would put the AIM program in direct conflict with due process.

ATTACHMENT A

http://www.medicinenet.com/script/main/art.asp?articlekey=619

downloaded May 30, 2008

Depression Risk Increased After Miscarriage

New York - Miscarriage can represent a physical stress to the body of a woman as well as lead to emotional trauma affecting women and their families.

According to the National Center for Health Statistics (1997), the pregnancies of approximately half a million women annually in the United States end in miscarriage. The impact of miscarriages is further underscored by current estimates that nearly 20 percent of recognized pregnancies end in miscarriage.

In a study published in the *Journal of the American Medical Association* (1997;277:383-388) Dr. Richard Neugebauer and colleagues compared the risk for an episode of major depressive disorder among miscarrying women in the first 6 months after their loss of pregnancy with community women who had not been pregnant.

Dr. Neugebauer's study found that there was a significant risk of depression in women after miscarriage. Furthermore, 72 percent of the episodes of major depression occurred during the first month after the loss of the pregnancy.

The study also found that the risk for depression was substantially higher for those miscarrying women who had no children. Further, the data demonstrated that over half of the women with prior histories of major depression experienced recurrences after they had miscarriages.

The authors conclude that women should be monitored for signs of depression during the weeks after miscarriage.

For more information, please visit the Miscarriage Center.

ATTACHMENT B

http://www.mja.com.au/public/issues/176_06_180302/boy10076.html

Downloaded May 30, 2008

eMJA The Medical Journal of Australia

Editorials

Pregnancy loss: a major life event affecting emotional health and well-being

Philip M Boyce, John T Condon and David A Ellwood
MJA 2002; 176 (6): 250-251

Comprehensive management of pregnancy loss is enhanced by psychological support and follow-up counselling

It is generally accepted that 12%–15% of confirmed pregnancies do not progress to term, with the risk of pregnancy loss increasing with maternal age. In particular, early pregnancy loss (< 20 weeks' gestation) is experienced by one in four women. In about half these women, a medical explanation can be found,1 although, in clinical practice, investigations to identify the cause are rarely pursued. Most women go on to have successful subsequent pregnancies, although there is a slightly increased risk of a second miscarriage that increases incrementally with each subsequent loss.1

Although early-pregnancy loss is relatively straightforward medically, the psychological outcome is more problematic and the grieving process is complicated.2 First, there is no tangible life or memory to grieve. Instead, the woman has to come to terms with grieving for a potential life with all its hopes and aspirations. Second, the grieving is often complicated by feelings of self-blame, particularly when there is no medical explanation for the loss or the woman has engaged in potentially hazardous behaviour (eg, alcohol consumption or smoking). Her partner may also harbour feelings of responsibility for the loss.

Other factors which may influence the grieving process and the emotional outcome include miscarrying later in gestation (especially if the woman has felt the fetus move and formed an emotional attachment to it);2,3 the importance and meaning of the pregnancy (eg, a first, wanted pregnancy lost near the end of the reproductive lifespan); and the difficulty experienced in conceiving the pregnancy (eg, an assisted conception). Finally, psychosocial factors, such as a woman's support network (especially her intimate relationship) and her personality style and culture, will affect how she appraises her loss and her level of distress.

The psychological sequelae after a late pregnancy loss and stillbirth are well described;3 those after an early pregnancy loss are similar but may not be as severe.

- There can be high levels of psychological distress characterised by anxiety, depression and somatisation, which can persist for at least six months4 and are only partly accounted for by grieving for the loss of a potential child.
- There is an increased risk of developing a depressive or anxiety disorder in the six months after a pregnancy loss, and any pre-existing psychotic disorders can be precipitated.

The risk of developing depression is high, with studies reporting rates between 10%5 and 48%,6 depending on the study methods.7 One of the more rigorous controlled studies5 reported that 10.9% of women developed major depression after a miscarriage, compared with 4.3% of women (controls) from the same community who had not been pregnant in the previous year. Depression is more likely in women with a history of depression or past psychopathology, and in women who have had a previous pregnancy loss or have no other children. Other factors precipitating depression, such as poor social support or having a vulnerable personality style, are well recognised. The rates of anxiety disorder are lower than those for depression. Recently, exacerbation of obsessive–compulsive disorder after miscarriage has been reported.8 Finally, if the pregnancy loss has been traumatic (eg, an ectopic pregnancy or the woman's life was at risk), post-traumatic stress disorder can arise.9

The comprehensive management of pregnancy loss will be enhanced by psychological support and follow-up counselling.7,10 This can be provided by the woman's obstetrician, general practitioner or another health professional involved in her care, who can address medical as well as psychological issues.11 The purpose is to allow open discussion about the loss, monitor progress and counsel the woman about future pregnancies. In the initial stages, she will benefit from the opportunity to talk about her loss and have her grieving acknowledged. Providing information about the normal grief process may help a woman who is masking her grief or does not believe it is legitimate. The grief process will be facilitated by the opportunity to talk about feelings of guilt and self-blame, particularly when there is no medical explanation.12,13 In our opinion, there should also be an opportunity to discuss dissatisfaction with medical care, as the woman may feel angry and blame her medical practitioner for the loss. An open discussion about this will help her, and may reduce the possibility of litigation.

Medical practitioners, particularly when the issue is pregnancy loss or stillbirth, are often reluctant to use the phrase "I'm sorry" because of fears that this equates with an acknowledgement of guilt and may have legal implications. Bereaved parents are often highly aware of this omission, angered by it, and may actually retaliate through litigation. Both obstetricians and insurance companies need to seriously look at the distinction between empathic expression of "sorrow" for the distress experienced as opposed to an apology for negligent action.

Regular follow-up is recommended for the first six months. Distinguishing between feelings of grief (which may require grief counselling) and the onset of a depressive illness (which may require specific treatment) can be difficult. Depression is suggested by persistence of depressed mood, lack of enjoyment in pleasurable activities, low self-esteem or excessive guilt, and sleep or appetite disturbance or fatigue.14,15 A pathological grief reaction, characterised by excessive distress, guilt feelings or a preoccupation with the loss, may require more specific counselling.

Sometimes a woman may have her depressed feelings dismissed as "grieving" and miss out on appropriate and effective treatment for a depressive disorder.

Other family members may also need psychological support. The woman's partner may experience similar feelings of loss.16 In such situations, the father is often neglected ("men aren't expected to talk about their feelings"). He will also benefit from an opportunity to talk about his feelings of loss, as will other children in the family, especially as they may feel responsible if they had feelings of jealousy about the new sibling.

The sense of loss may dissipate when the woman becomes pregnant again, and some studies suggest that the shorter the time between a pregnancy loss and a subsequent pregnancy the better the outcome for the woman.13 Such women usually feel anxious during the stage of pregnancy at which the previous loss occurred. Finally, women may benefit from the opportunity to talk to other women who have experienced a pregnancy loss through support groups such as SANDS <http://www.sands.org.au/>.

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ATTACHMENT C

Sharing Pain of Miscarriage

Helps Women Overcome Loss

(May 15, 2007)

ATTACHMENT C

May 15, 2007

Sharing pain of miscarriage helps women overcome loss

DEAR ABBY: After reading the letter from "Anonymous in the North" (March 12), I had to write. I, too, have suffered a miscarriage. Not only did I mourn the loss of my pregnancy, but I was also afraid I'd never be able to have any children.

"Anonymous" should know that one in four pregnancies ends in miscarriage. If she talks with other women, she'll see she's not alone in her suffering. Sharing her story with others who have been through the same thing may help her ease the pain she's feeling.

Nine months after my miscarriage I became pregnant again with my son. The happiest moment of my life was when I saw his heartbeat on an ultrasound and was later able to hold him in my arms. I am now the happy mother of three. Please extend my sympathies to "Anonymous," and tell her not to give up hope.
— ANOTHER MOM IN THE NORTH

DEAR MOM: I was touched by the number of women who wrote to support "Anonymous in the North," and amazed at how many of them said that they had had miscarriages, too. One reader suggested that "Anonymous" contact area hospitals to see if there is a local support group for parents who have suffered infant loss, explaining that it helped her cope with her own grief.

Abigail Van Buren

A national group that has helped many people is Share: Pregnancy and Infant Loss Support Inc. Founded in 1977, it has 80 chapters and offers mutual support for bereaved parents and families who have suffered a loss due to miscarriage, stillbirth or neonatal death. It provides a monitored interactive Web site that includes chat rooms and message boards. Its toll-free number is (800) 821-6819, and its Web site is www.nationalshareoffice.com. Read on:

▲▲▲

DEAR ABBY: "Anonymous in the North" needs to realize that her anger and bitterness are normal. You don't get "over" a miscarriage, but you do get through it — and life does get better.

What she needs to do is take care of herself. If that means avoiding or limiting her time with her brother and pregnant sister-in-law, or friends and family with babies, so be it! They need to understand that it isn't about them.

Things not to say to someone who has miscarried:

1. "You'll get pregnant again." (Not everyone does.)
2. "You can always adopt." (That's a personal decision and should not be rushed into as second best.)
3. "It was for the best because it was defective, it was God's will, etc." (Unforgivable, even if it were true.) If you don't know what to say about a friend's miscarriage, say "I'm so sorry," and shut up. Don't try to "fix it." — DANA IN SPRINGFIELD, MO.

▲▲▲

DEAR ABBY: After my miscarriage it was hard for me to see a pregnant woman or baby. My doctor gave me a book that helped me understand and deal with my feelings. I hope "Anonymous" can get a similar reference from her doctor. — BEEN THERE AND GOT THROUGH IT

Write Dear Abby at www.DearAbby.com or P.O. Box 69440, Los Angeles, CA 90069.

Comment 3
R-2-08 45-Day Comment Period

PPAC
Planned Parenthood
Affiliates of California, Inc.
Providing responsible choices through advocacy and political action.

June 3, 2008

Managed Risk Medical Insurance Board
Attn: JoAnne French
1000 G Street, Suite 450
Sacramento, CA 95814

Re: Comments to Notice of Proposed Rulemaking R-2-08

Dear Ms. French:

Planned Parenthood Affiliates of California (PPAC), urges Managed Risk Medical Insurance Board (MRMIB) to extend a rebate to all women who miscarry and reject the elimination of the existing 20-day prior notice of termination of Access for Infant and Mothers (AIM) benefits.

Currently, the AIM program requires continual payments by the patient despite a miscarriage and limiting enrollment to pregnancy care to those under 30 weeks pregnant. PPAC appreciates the action taken to provide a rebate to those women who miscarry in the first trimester of their pregnancy and are able to inform Access for Infants and Mothers (AIM) of their miscarriage. The ability for women to avoid a painful reminder of their loss in the form of continued billing is an important policy that we hope the AIM program will maintain.

However, PPAC strongly urges MRMIB to extend this policy to *all* women who miscarry, regardless of the stage in pregnancy. The exclusion of women in the second trimester from similar relief is arbitrary, especially since the exact cut-off date between the first and second trimesters can be imprecise. Furthermore, later miscarriages are often exceedingly traumatic to women who have had a longer period of time with their pregnancies and continuing to bill women for their pregnancy-related coverage poses to exacerbate an already difficult time.

Additionally, these regulations address a second issue not reflected in the title: the elimination of the existing 20-day prior notice of termination of AIM benefits and health plan coverage. It is critical that prior notice be given to all AIM beneficiaries women before a termination of coverage. It is critical that materials provided by AIM clearly instruct beneficiaries to contact the AIM program as soon as they have miscarried or the Healthy Families program as soon as a baby is born. If women are not made aware that

their health coverage is about to end, they may be in danger of incurring significant medical bills under false assumptions about their benefits and/or coverage.

PPAC urges MRMIB to continue to provide the 20-day prior notice to women of the termination of their AIM program benefits and health plan coverage. PPAC also strongly urges MRMIB to extend the rebate policy to *all* women who miscarry, regardless of the stage in pregnancy. We urge your reconsideration.

Sincerely,

Ann Marie Benitez
Public Policy Director

Comment 4
R-2-08 45-Day Comment Period

French, JoAnne

From: Lydia Boyd [LBoyd@labestbabies.org] on behalf of Carolina Reyes [CReyes@labestbabies.org]
Sent: Tuesday, June 03, 2008 2:17 PM
To: French, JoAnne
Cc: Tonya Gorham
Subject: RE: R-2-08, Proposed AIM Reduced Rates After 1st Trimester Miscarriage

Dear Members of the Managed Risk Medical Insurance Board:

LA Best Babies Network is dedicated to achieving healthy pregnancies and improving birth outcomes in Los Angeles County. The LA Best Babies Network is the coordinating arm of the First 5 LA Healthy Births Initiative an investment which provides the opportunity to enhance perinatal and interconception care by investing in a strong, community-based network of caregivers and advocates dedicated to preventing low birth weight and premature deliveries. The Initiative focuses on improving service delivery and access to care in those areas in Los Angeles with the greatest need, the highest infant mortality, and the highest number of low birth weight infants and the highest rates of prematurity.

Thank you for the action you have taken to provide a rebate to those women who miscarry in the first trimester of their pregnancy and are able to inform AIM of this tragic occurrence. The ability for women to avoid a painful reminder of their loss in the form of continued billing is a good first step to address what we hope will be additional work on AIM. Specifically, we want continued billing to be dropped for ALL women who miscarry, both because trimesters are often somewhat arbitrary and because of the impact of later miscarriages. Second and third trimester miscarriages might be even more painful and tragic to women who've had a longer period of time with their pregnancies and for whom a miscarriage may be a more complex occurrence requiring even more follow-up.

These regulations also address a critical second issue not reflected in the title-– elimination of the existing 20-day prior notice of termination of AIM benefits and health plan coverage. Prior notice must be given to *all* women with AIM. Most enrollees get billed by AIM for 12 months and believe they continue to have insurance as long as they send in their AIM payments on time; prior notice that AIM benefits and coverage are ending is key to avoiding confusion for AIM enrollees. In addition, when AIM decides to disenroll a woman for cause under the proposed regulations AIM would not tell the woman about the allegations against allowing her a chance to appeal before disenrollment. If women are not made aware that their health coverage is about to end, they are in danger of accumulating medical bills they can't afford.

It is completely unnecessary to eliminate the 20-day prior notice to women that their AIM program benefits and health plan coverage are ending. MRMIB should not make this change.

Sincerely,

Carolina Reyes, MD

Executive Director

LA Best Babies Network

350 South Bixel Street, Suite 100

Los Angeles, CA 90017

Tel: (213) 250-7273, ext. 123

Fax: (213) 250-7212

CReyes@LABestBabies.org

Sign up for *Perinatal e-News* at www.LABestBabies.org

Comment 5
R-2-08 45-Day Comment Period

June 3, 2008

Managed Risk Medical Insurance Board
Attn: JoAnne French
P.O. Box 2769
Sacramento, CA 95812-2769
FAX: (916) 324-4878

Re: R-2-08, *Proposed AIM Reduced Rates After 1st Trimester Miscarriage*

100% Campaign
Headquarters
1212 Broadway, 5th Floor
Oakland, CA 94612
(510) 763-2444
(510) 763-1974 fax
100percentcampaign.org

The Children's
Partnership
1351 3rd St. Promenade
Suite 206
Santa Monica, CA 90401
(310) 260-1220
(310) 260-1921 fax

Children Now
1212 Broadway
Fifth Floor
Oakland, CA 94612
(510) 763-2444
(510) 763-1974 fax

1127 Eleventh St., Suite 452
Sacramento, CA 95814
(916) 443-1680
(916) 443-1204 fax

Children's
Defense Fund
2201 Broadway, Suite 705
Oakland, CA 94612
(510) 663-3224
(510) 663-1783 fax

3655 S. Grand Avenue
Suite 270
Los Angeles, CA 90007
(213) 749-8787
(213) 749-4119 fax

Dear Members of the Managed Risk Medical Insurance Board:

The 100% Campaign – a collaborative effort of The Children's Partnership, Children Now, and Children's Defense Fund California – as advocates for children's and families' health, believes that the Access for Infants and Mothers (AIM) program should continue to provide pregnant women with available and appropriate access to health care insurance during their pregnancies and post-partum. We are writing to express concern with some aspects of the proposed AIM regulation R-2-08, "Proposed AIM Reduced Rates After 1st Trimester Miscarriage."

We are pleased that MRMIB has established procedures to provide a rebate and avoid continued billing to those women who miscarry in the first trimester of their pregnancies and who inform AIM of this fact. However, we would like MRMIB to extend these procedures to all women who miscarry, both because later miscarriages often involve more extensive medical follow-up and because the demarcation between first and second trimester is not always exact.

We are, however, extremely concerned that the proposed regulations address a second issue not reflected in their title: elimination of the existing 20-day prior notice of AIM termination. Most AIM enrollees get billed for 12 months and believe, understandably, that they continue to have insurance as long as they send in their AIM payments on time. Prior notice that AIM benefits and coverage are ending is thus key to avoiding confusion for all AIM enrollees. If women are not made aware that their health coverage is about to end, they are in danger of incurring medical bills that they can't afford, thinking that AIM will pay for them. Elimination of the existing 20-day prior notice of termination of AIM benefits and health plan coverage would have potentially serious consequences for all AIM enrollees.

In addition, when AIM decides to disenroll a woman for cause, under the proposed regulations, AIM would not tell the woman about the allegations against her beforehand or give the woman a chance to tell her side of the story before disenrolling her. This proposed policy is unfair and unnecessary.

We urge you *not* to eliminate the 20-day prior notice to women that their AIM program benefits and health plan coverage are ending.

We also look forward to working with you towards improving the miscarriage proposal.

Because the AIM program is so critical to a healthy beginning for children, it is vitally important that the program is run in a manner that fulfills the trust that pregnant woman place in its coverage.

Thank you for your consideration.

Sincerely,

Wendy Lazarus
Founder and Co-President
The Children's Partnership

Ted Lempert
President
Children Now

Cliff Sarkin
Senior Policy Associate
Children's Defense Fund-California

CC: Lesley Cummings, MRMIB
Lynn Kersey, Maternal and Child Health Access

Comment 6
R-2-08 45-Day Comment Period

Asian Law Alliance
184 E. Jackson Street
San Jose, CA 95112
Telephone: (408) 287-9710
Fax: (408) 287-0864

June 3, 2008

Ms. JoAnne French
Managed Risk Medical Insurance Board
1000 G Street, Suite 450
Sacramento, CA 95814
jfrench@mrmib.ca.gov
FAX (916) 327-6580

Re: R-2-08--Proposed Changes to AIM Regulations – Comments

Dear Ms. French:

The Asian Law Alliance is a non-profit community law office that serves primarily low-income, limited English speaking immigrants in Santa Clara County. The Asian Law Alliance supports MRMIB's efforts to improve the AIM (Access for Infants and Mothers) Program and submits the following comments and recommendations based upon my experience representing Ms. X.

Ms. X and her husband are limited English-speaking immigrants from Vietnam. With assistance, Ms. X applied for the AIM Program even though the application form was in English. She received all accompanying instructions and the AIM Handbook in English. Ms. X was subsequently accepted as a subscriber. One day after her effective date of coverage, she suffered a miscarriage. On the following day, Ms. X's HMO authorized and her physician performed a miscarriage procedure.

Due to Ms. X's inability to read and understand the AIM Handbook in English, she did not understand that she was no longer eligible for the AIM Program. Over the course of the next several months, she made her full AIM subscriber contributions, her HMO authorized, and she received treatment for a number of medical problems. AIM pay for all of those bills.

Seven months later, Ms. X realized that there was a problem with her AIM insurance after a conversation with her doctor. She immediately called the HMO and was told by a Vietnamese-speaking worker that the HMO did not know why her AIM insurance had been terminated. Thereafter, Ms. X's husband contacted AIM and was told by a Vietnamese speaker to file an appeal. During this time period, AIM retroactively disenrolled Ms. X from the AIM Program and left her with almost $25,000 in medical services that had been previously pre-authorized

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R-2-08 Comment 7
AIM 1st Trimester Rule

June 3, 2008

Managed Risk Medical Insurance Board
Attn: JoAnn French
1000 G. St., Suite 450
Sacramento, CA. 95814

RE: R-2-08, Proposed AIM Reduced Rates After 1st Trimester Miscarriage

Dear Members of the Managed Risk Medical Insurance Board:

At ACCESS/Women's Health Rights Coalition we run, amongst other things, an information and referral Healthline that women call when faced with questions about reproductive health and rights including their pregnancy options, family planning, prenatal care and how to pay for services. We work with women everyday who are pregnant and need to find free or low-cost resources to be able to obtain adequate prenatal and labor and delivery care, and to be able to parent their children and help them thrive. We hear from women everyday who have one or several jobs and yet are unable to pay for private health insurance, but also don't qualify for Medi-Cal. For these women, the Access for Infants and Mothers (AIM) program may be their only resource, and so it is imperative that AIM remains accessible and affordable for the countless women who rely on the program.

Thank you for your action to provide a rebate to those women who miscarry in the first trimester of their pregnancy and are able to inform AIM of this unfortunate occurrence. Avoiding continued billing for these women is a great first step in helping alleviate their stress after having a miscarriage, and we hope this will lead to more work by AIM to ensure that ALL women who miscarry are afforded this rebate. Specifically, we want continued billing to be dropped for ALL women who miscarry, regardless of gestational age, both because measuring trimesters is often arbitrary and because the impact of later miscarriages may be more complicated. Second and third trimester miscarriages might be even more difficult physically and sometimes emotionally for women who carry their pregnancies for a longer time and for whom a complex miscarriage may require additional follow-up.

Despite our support for the main proposal in the new regulations, we are concerned about a second issue not reflected in the title—mainly the elimination of the existing 20-day prior notice of termination of AIM benefits and health plan coverage. We feel strongly that this prior notice must be given to ALL women with AIM.

Most enrollees are billed by AIM for 12 months straight, even after their pregnancies end, and reasonably believe that they will continue to have insurance as long as they send in their AIM payments on time. This is confusion that many women cannot afford. If women are not made aware that their health coverage is about to end, they are in danger of piling up huge medical bills which they may not be able to cover, thinking that AIM will pay for them. Thus, prior notice that AIM benefits and coverage are ending is essential to avoid confusion and needless money spent for AIM enrollees.

P.O. Box 3609
Oakland CA 94609

510.923.0739 tel
510.923.0014 fax

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making choice a reality

In addition, it is categorically unfair that under the proposed regulations AIM may not tell a woman the reasons behind her disenrollment or give her a chance to respond to allegations made against her. An AIM recipient must be allowed at least 20 days notice, if not more time, in order to present necessary supplemental documentation to support an application or case in question.

Eliminating the 20 day prior notice of disenrollment, will also affect those women who have miscarried and may not have the time, the emotional state nor the health to report their miscarriages immediately, by leaving them in the dark about when their benefits will end. It is important that AIM's materials instruct women to contact the AIM program as soon as they have miscarried or the Healthy Families program as soon as a baby is born-- but these warning materials are not enough to ensure that women have the space and time to make this report post-pregnancy. It is thus critical that women be given a notice before their benefits expire, and since there is no clear reason to eliminate the 20-day prior notice before disenrollment from AIM, MRMIB should not make this change.

Sincerely,

Destiny Lopez
Executive Director

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whrc-access.org

Public Comment From

15-Day Notice Period

Maternal and Child Health Access

1111 W. Sixth Street, Suite 400
Los Angeles, CA 90017-1800
Tel 213. 749. 4261
Fax 213. 745. 1040
www.mchaccess.org

June 17, 2008

Managed Risk Medical Insurance Board
Attn: JoAnne French
1000 G Street, Suite 450
Sacramento, CA 95814
jfrench@mrmib.ca.gov
FAX (916) 327-6580

Re: R-2-08, Notice of Modifications to the Text of *Proposed AIM Reduced Subscriber Contributions Following First Trimester Miscarriage*

Dear Ms. French:

A hearing on R-2-08 was held on June 3, 2008. MCHA and several other organizations submitted comments objecting to the proposed repeal of AIM's 20-day prior notice of termination of benefits (proposed amendment to § 2699.209(b)) and continuation of the practice of retroactive health plan disenrollment.

On June 4, 2008, AIM issued a modified text for two of the regulations, §§ 2699.207 and 2699.209. This letter will serve as the written comments on the modifications of MCHA and the Asian Law Alliance.

1) **The modifications involving termination and disenrollment from AIM when it is alleged that the woman is not a resident of California or that she has committed fraud must be further modified to: (a) ensure the right to have benefits continue pending an appeal; (b) include this right in the notice of disenrollment's explanation of the appeals process; and (c) ensure the right to an impartial adjudicator.**

At present, § 2699.209(b) provides that every AIM subscriber "shall be notified of the date her coverage ends and such notice will be provided at least twenty (20) days prior to that date." Under existing § 2699.207(b), a "subscriber shall be notified by the program in writing of the disenrollment. . .from the program, the effective date, and the reason for the disenrollment." Taken together, these two existing regulations provide for 20-days prior written notice of the termination of AIM benefits and health plan disenrollment, with the effective date and reason.

The original proposed amendment to § 2699.209(b) repealed the 20-day prior notice requirement for all AIM enrollees. Among the reasons for MCHA's objections was that repealing the prior notice rule would deprive AIM enrollees of an opportunity to challenge terminations based on allegations that the woman was not a resident of California or that she had somehow committed fraud.

The modified text partially addresses this objection by providing for 10-days' prior written notice where the reason for the proposed termination is alleged lack of state residency or fraud (see proposed modified § 2699.207(d) and (e)). Under proposed subdivision (b) of § 2699.207, the 10-day notice is to include the reason for the disenrollment, the effective date of the disenrollment, and an explanation of the appeals process.

Even with the recent modifications, however, the text of the proposed regulations still violates the consistency standard of the Administrative Procedures Act (APA) (Government Code (Gov. C.) § 11349(d)), as the proposed regulations continue to ignore basic tenets of due process.

(a) Continuation of AIM benefits pending completion of the appeal

The modifications fail to mention the right of an AIM enrollee to have her benefits continue during the hearing process should she request an appeal. Under 42 C.F.R. § 457.1140(d)(4), states must ensure that enrollees in their SCHIP-funded programs, such as AIM, "have an opportunity to. . .[r]eceive continued enrollment in accordance with § 457.1170" when they appeal. Under 42 C.F.R. § 457.1170, a "State must ensure the opportunity for continuation of enrollment pending the completion of review of a suspension or termination of enrollment. . ."

Thus, the right to continue receiving benefits pending an appeal must be added to Article 5 of AIM's regulations (Appeals, §§ 2699.500 *et seq.*).

In addition, proposed § 2699.207(b)(3) must be modified as follows (underline indicates proposed insertion): "The notice shall. . include. . [a]n explanation of the appeals process, including continuation of benefits pending completion of the appeals process."

(b) Impartial adjudicator

Under 42 C.F.R.. § 457.1140(a), appeals in an S-CHIP-funded program, like AIM, must be "conducted by an impartial person or entity in accordance with § 457.1150." Under subdivision (a) of 42 C.F.R. § 457.1150, appeals involving eligibility decisions "must be conducted by a person or entity who has not been directly involved in the matter under review."

Under § 2699.500(b)(1) and (2) of AIM's existing Appeals regulations, eligibility and disenrollment issues "may be appealed to the Executive Director *only*" [Emphasis added]. The Executive Director does not meet the criteria for impartiality under 42 C.F.R. § 457.1150(a), as he or she is directly responsible for the eligibility and disenrollment decisions made by AIM.

Subdivision (b) of § 2699.500 excludes the Board from hearing eligibility and disenrollment appeals (*cf.* subdivision (a) of § 2699.500, providing for appeal to the Board when the issue is health plan coverage instead of eligibility or disenrollment). And because the Appeals regulations expressly provide that eligibility and disenrollment appeals can be made "only" to the Executive Director (§ 2699.500(b)(1) and (2)), it is unclear whether an "administrative hearing" conducted by an impartial adjudicator of the Office of Administrative Hearings, as provided for under § 2699.504, is available for an eligibility or disenrollment appeal.

For these reasons, § 2699.500(b), which is implicitly incorporated by reference into the proposed modifications to § 2699.207(d) and (e), must be clarified to ensure that women being disenrolled from AIM for alleged lack of California residency or fraud can choose to have their cases heard by an impartial adjudicator at an administrative hearing under § 2699.504 instead of "only" by the Executive Director under § 2699.500(b).

2) **The modifications are insufficient in that they address due process concerns only when termination and disenrollment from AIM is related to an enrollee's alleged lack of state residency or fraud.**

Under proposed § 2699.207(g) and proposed amended § 2699.209(b), plan disenrollment of AIM enrollees whose eligibility is ending because the pregnancy is over would take effect on the 61st day after the end of the pregnancy, without prior notice. Thus, the modifications do not address the other reasons identified in MCHA's June 3 comments why repeal of the current 20-day prior written notice rule in § 2699.209(b) is both bad policy and inconsistent with due process. We incorporate those earlier comments by reference here, as if set forth in full (see pages 2-3, 9-11-15).

To briefly summarize, prior notice is required by due process not only to provide an opportunity to challenge the reason proffered for the termination of benefits, but also to give program beneficiaries an opportunity to adequately prepare for the impending loss of benefits. While AIM may have administrative concerns about providing prior notice to women to warn them that their health insurance is about to end and informing them of the specific date on which disenrollment will occur, such concerns must be balanced against the very real harms that AIM's retroactive disenrollments cause women. (*See, e.g.*, letter from Asian Law Alliance, June 3, 2008, submitted to the June 3 hearing record).

Moreover, in some cases, the notice is necessary both to warn the woman of the exact date of the loss of benefits in time to prepare, and also to challenge the date of the proposed termination, such as when there is a dispute as to when the pregnancy actually ended, a not uncommon situation when miscarriage is involved.

The existing 20-day prior notice of termination of coverage under § 2699.209(b) must be retained if AIM regulations are to be consistent with due process.

3) **The modifications are insufficient in that they ignore reasonable alternatives to AIM's proposed repeal of the existing 20-day prior notice requirement.**

Also in our earlier comments, we set forth two alternatives to ending the 20-day prior written notice rule (see pages 4-5).

The first alternative was for the AIM program to conduct its case reviews shortly after a woman's estimated due date, instead of waiting until the 11th month after her AIM application date. Review closer to the expected time of the end of the pregnancy would allow for 20-days' prior notice from the AIM program before the expiration of the 60-day post-partum coverage period; this in turn would eliminate retroactive disenrollments, which often go back many months under AIM's current policies and procedures. AIM case reviews would only be

necessary when a woman has not already communicated to AIM that her pregnancy has ended, either by enrolling her newborn into Healthy Families or through some direct communication with the AIM program.

The second proposed alternative in our earlier comments is a variation on this theme: instead of waiting until the 11th month after the date of application, the AIM program could conduct the case reviews within 120 days of the woman's expected due date. With this approach, many more of the women would have already reported their newborns to Healthy Families for enrollment; thus, fewer case reviews of the mother's AIM eligibility would be necessary. There would also be ample time for issuance of the 20-day prior notice terminating the mother's AIM coverage.

Failure to adequately consider these alternatives violates the APA (*see* Gov. C. §§ 11346.2(b)(3)(A) and (B) and 11346.3(a)).

4) **The modifications would require AIM enrollees to report the end of their pregnancies within 30 days as a condition of avoiding retroactive diesnrollment many months after the fact. The magnitude of this modification requires that it be dropped as insufficiently related to the original R-2-08 filing, lacking in adequate notice, and in need of careful consideration of proposed alternatives.**

The text of § 2699.209(b) has been modified to impose a brand new regulatory burden on AIM enrollees, one that has never formally existed in AIM's regulations or governing statute before. Under the modified text, an AIM subscriber must "notify the program of the date on which the pregnancy for which she enrolled ends," and the notice must be provided "by the thirtieth day after the end of the pregnancy." Contrary to the boilerplate language in the Notice of Modifications, this major new regulatory burden is not sufficiently related to the initial regulations proposed in R-2-08.

Instead, this new proposed text underscores the unlawful underground rule (*see* APA Gov. C. § 11340.5(a)) that has been the premise for AIM's retroactive disenrollments: the hidden requirement that enrollees report the end of their pregnancies to AIM. The program has been using this rule without any statutory or regulatory authority, and without directly informing enrollees, providers, consumer advocates or the general public of its existence; a woman who "fails" to notify the program that her pregnancy is over is penalized with *retroactive* disenrollment from her health plan, exposing her to financial liability for medical services she may have received in the interim. This puts women in an untenable position, exposing them to serious risk of medical bankruptcy. (*See, e.g.*, letter from Asian Law Alliance, June 3, 2008, submitted to the June 3 hearing record).

(a) The modification must be dropped because it is not sufficiently related to the regulations originally proposed in R-2-08.

The APA permits post-hearing modifications to proposed regulations if the modifications are "sufficiently related to the original text that the public was adequately placed on notice that the change could result from the originally proposed regulatory action." (Gov. C. § 11346.8(c)(2)). Not a single word, phrase or concept in the original R-2-08 filing proposed imposing a burden on AIM enrollees to report the end of their pregnancies to the AIM program. The text modification

to make women responsible for reporting the end of their pregnancies to AIM in 30 days is completely new to R-2-08 and in no reasonable understanding of the term is it "sufficiently related" to the original proposed regulation filing. The modification therefore must be rejected under Gov. C. § 11346.8(c)(2) alone.

(b) Inadequate Notice of Rulemaking

Moreover, like AIM's original proposal to repeal the 20-day prior notice requirement of § 2699.209(b), the modification requiring women to report the end of their pregnancies to AIM within 30 days goes far beyond the description of R-2-08, which was limited to *AIM Reduced Subscriber Contributions Following First Trimester Miscarriage*. Therefore, before the proposed new requirement that women report the end of their pregnancies to AIM in 30 days could acquire any semblance of legitimacy, a new Notice of Rulemaking would be required (*see* APA Gov. C. § 11345.2(b) and 11346.5(a)(3)(A)-(C)).

(c) Unlawful underground rules and careful consideration of proposed alternatives

The AIM program has tacitly admitted, via the modified text of § 2699.209(b), that the program's underground norm is to retroactively disenroll women for their "failure" to notify the program of the end of the pregnancy.

Transforming the underground rule into a formal regulation will not eliminate the harms from retroactive disenrollment for the many low-income women enrolling in AIM who, due to limited English language skills, illiteracy in their native language, severe and prolonged post-partum depression, and other reasons, may not report the end of their pregnancies to the state within 30 days.

Nor will transforming the underground rule into a regulation cure the due process violations that flow from: (1) repealing the current rule, which requires AIM to give women at least 20-days' prior notice before ending their coverage; and (2) replacing AIM's existing obligation to provide enrollees with 20-days' prior notice with a burden on the enrollees instead to report the end of their pregnancies to AIM in 30 days.

At a minimum, then, the AIM program must seriously consider alternatives to the new 30-day reporting burden, such as the two presented by MCHA on June 3 and summarized above.

5) **The modification of § 2699.209(b) fails to meet the APA's clarity and consistency standards as it provides no information about what "reporting" a pregnancy requires to avoid retroactive disenrollment and otherwise fails to meet due process.**

As noted above, the modified text of § 2699.209(b) requiring women to notify AIM of the end of their pregnancies in 30 days must be rejected for a broad range of reasons. But if it is retained despite its serious legal flaws, the following changes are fundamental to addressing clarity and consistency with due process (*see* APA, Gov. C. §§ 11349(c) and (d), respectively):

(a) Explain what actions constitute "notification": Actions that constitute "notification" must be identified in the regulations. For example, the regulations should clearly specify that

enrolling her newborn into Healthy Families simultaneously counts as the woman's notification to the AIM program that her pregnancy has ended.

(b) Clarify that acceptable notification of the end of a pregnancy may be given by others with the woman's permission: The regulation must also clarify that notification from a doctor, clinic, health plan or any other person acting with the woman's permission that the woman's pregnancy has ended will also satisfy the administrative burden imposed on the woman by this proposed new rule. This clarification is especially important for women who are too sick or clinically depressed to function within 30 days of giving birth or experiencing a miscarriage or who lack the necessary language or literacy skills.

(c) Clarify what "by the thirtieth day" means: The regulations should clearly specify that a post-mark from the U.S. mail satisfies the requirement to "provide . ..notification *by* the thirtieth day after the end of the pregnancy" [Emphasis added].

(d) For women who *do* notify AIM within 30 days of the end of the pregnancy, 20-days prior notice of termination and plan disenrollment must be provided: The regulation must also clarify all of the following as to women who do notify AIM, or on whose behalf notification is given, within 30 days of the end of the pregnancy:

- Such women will be sent ***prior*** written notice from the AIM program of the termination of their AIM benefits and disenrollment from their health plans.
    - While proposed § 2699.207(b) does provide for written notice of disenrollment, it does not guarantee that the notice will be given *prior* to the effective date of disenrollment.
- The notice will be sent at least ***20 days before*** the effective date of termination and disenrollment, as provided for in existing § 2699.209(b). The existing 20-day prior notice requirement is well within the 60-day post-partum period during which AIM eligibility and coverage continue (31 + 20 = 51 days).
- The notice will include all of the following:
    - the date on which the termination and disenrollment are to take effect (as indicated in proposed § 2699.207(b)(2));
    - the reason for termination and disenrollment (as indicated in proposed § 2699.207(b)(1)); and
    - an explanation of the appeals process, ***including the right to continue benefits pending appeal*** (see discussion above at page 2). While proposed § 2699.207(b)(3) does require an explanation of the appeals process, it is silent on the right to continue benefits pending appeal.
        - Continuation of benefits pending the appeal is important for all AIM enrollees, but it is especially important for women who AIM claims

miscarried *before* the effective date of health plan coverage. For women who do miscarry before the effective date of coverage, there are no AIM benefits or health insurance coverage at all-- not for prenatal care, not for care related to the miscarriage itself, and not during the 60-day post-partum period. It is therefore imperative that a woman have the opportunity not only to present expert medical and other testimony about the true and correct date of the miscarriage but also to *continue to have AIM coverage until her appeal is completed.*

(e) For women who do *not* notify AIM within 30 days of the end of the pregnancy, the program must conduct case reviews on the 31st day after the estimated due date indicated in the woman's AIM application and provide 20-days' prior notice of termination of benefits and health plan disenrollment: Finally, there is the issue of how the AIM program will treat women who do not notify AIM by the 30th day after the end of the pregnancy. Will AIM continue to conduct case reviews of such cases? When? The current illegal underground practice of setting case reviews at eleven months after the date of the woman's AIM application and retroactively disenrolling women based on case reviews at such a late date must end.

(1) AIM case reviews for enrollees who do not enroll a newborn into Healthy Families or otherwise communicate the end of the pregnancy to AIM within 30 days should be conducted on the 31st day following the estimated due date instead of 11 months after the date of the woman's AIM application.

As indicated in our original comments and repeated above, MCHA believes the case reviews for women who have not enrolled their newborns into Healthy Families early or otherwise notified AIM that the pregnancy has ended must be conducted close to the woman's expected due date. With the proposed new requirement that an AIM subscriber notify the state within 30 days of the end of her pregnancy, the time for AIM to conduct its program reviews should be no later than the 31st day after the woman's expected due date; under no circumstances should AIM wait until the 11th month after the woman's application date to conduct the review, as AIM does now.

It is this potentially very long period of time between the date that eligibility technically ends (as early as the date of the application itself if the woman miscarries before her effective date of coverage; otherwise, the 61st day post-partum) and the time that the 11th month reviews are conducted that puts AIM enrollees at such great financial risk. AIM's decision to retroactively disenroll a woman does not occur until the case review is conducted, and during those 11 months before the case review occurs, the AIM program will continue to bill the women every month, including for months after the pregnancy's end. A woman may reasonably believe she remains eligible so long as she makes her monthly payments to AIM, and based on that reasonable assumption, she may continue to use her health plan during the long 11th month interval between her date of her application and her AIM case review.

For the relatively few women who will not have enrolled a newborn in Healthy Families within 30 days of the end of pregnancy, setting the date for AIM"s case reviews at the 31st day after the estimated due date indicated in the woman's AIM application is necessary to cure due process flaws and end the gross injustice of the current system.

(2) 20-days' prior written notice must also be retained for women receiving AIM case reviews on the 31st day following the estimated due date.

The 20-day prior written notice, with each of the elements listed above, must be provided to women at the completion of their individual AIM case reviews. If AIM conducts the reviews on or close to the 31st day after the estimated due date, as due process requires it must, there will be ample time for the 20-day prior written notice of termination of AIM benefits and health plan disenrollment before the 60-day post-partum coverage period ends (31 + 20 = 51 days).

6) The AIM program must provide an exception from the 30-day reporting requirement to address the unique circumstances and high risk of medical debt facing the miniscule percentage of AIM enrollees who miscarry. Failure to do so violates due process as well as laws prohibiting discriminating against persons with serious depression or other disabilities.

In the past, AIM staff have estimated that fewer than 60 of the approximately 11,500 women enrolled in AIM each year miscarry, or a negligible.005%. As AIM enrollment is now estimated at 13,907 per year *(see* Attachment D, *Senate Budget Subcommittee No. 3*, page 15), we increase the estimated number of miscarriages accordingly (.005 x 13,907 = 70). With our June 3 comments, we included several brief summaries of the increased depression risks after miscarriage (Attachments A-C), which we now incorporate by reference.

The proposed changes to § 2699.209(b) placing the burden on all AIM enrollees to report the end of their pregnancies to AIM in 30 days and doing away with the 20-day prior notice of disenrollment requirement are especially harsh with respect to the tiny minority of enrollees who miscarry and are at greatest risk of suffering debilitating depression. Not even the alternatives we describe above, which would have the AIM program conduct case reviews on the 31st day after an enrollee's expected due date, address the unique situation of these women, as most of the 70 annual miscarriages will occur during the first trimester, and the estimated due date for triggering case reviews under our proposed alternative won't occur until six months later.

A special rule is therefore desperately needed to address the unique circumstances of the 70 women each year who miscarry while enrolled in AIM.

a) Health plans and providers should be required to report miscarriages on behalf of the tiny percent of AIM enrollees who miscarry.

At several public hearings before the Board, MCHA and others have recommended that, for the very small number of women affected by this issue each year, health plans and networked providers doing business with the AIM program should have, or at least share, the responsibility to report to AIM whenever medical services for a miscarriage has been provided to an AIM enrollee. To date, the response of staff and the Board has been that such a requirement would be too burdensome on the health plans. Yet, shortly after the Board rejected this modest proposal to fend off medical bankruptcy for the most vulnerable of AIM enrollees, AIM proposed increasing its average annual health plan capitation rate from $9,641 to $10, 469 per woman *(see* Attachment D). With this change in circumstances and increased compensation, the burden to the plans should now be light enough to report miscarriages to AIM, especially since, with nine

health plans participating in AIM as of this writing, no single plan would have the total responsibility. Assuming the 70 annual miscarriages are distributed evenly among the plans, each plan would have to report only about 7 or 8 times a year.

b) Alternatively, AIM should cover the medical services a woman who miscarries receives during what would have been her period of retroactive disenrollment.

Alternatively, AIM could simply agree to cover medical services received by women whose miscarriages do not come to the program's attention until the case review on the 31st day after the woman's estimated due date. The federal S-CHIP program would pay for two-thirds of the cost, as it does for all of AIM's other costs.

Sincerely,

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California State Senate

COMMITTEE
ON
BUDGET AND FISCAL REVIEW

ROOM 5019, STATE CAPITOL
SACRAMENTO, CA 95814

SENATOR
DENISE MORENO DUCHENY
CHAIR

Agenda
May 30, 2008
10 a.m. - Room 4203

HEALTH

Attachment D

Program Description	Comments
Access for Infants and Mothers (AIM) Program (May Revise) For 2008-09, the May Revision reflects a total annual enrollment of 13,907 pregnant women (monthly average of 1,159 women) in AIM which is a reduction of 1,929 women (reduction in the monthly average of 161 women) as compared to January. The revised estimate assumes total expenditures of $146.6 million ($65.5 million Perinatal Insurance Fund and $81.1 million federal funds) for a reduction of $7.2 million (reduction of $3.3 million Perinatal Insurance Fund and reduction of $3.9 million federal funds) primarily from the caseload adjustment. It should be noted this estimate also reflects an increase in the average one-time capitation rate to $10,468.70 for the budget year, versus the previous amount of $9,641.36. Since the capitation fees vary by plan, the distribution of participants by plan effects the statewide monthly average used in the estimate. The AIM Program provides health insurance coverage to women during pregnancy and up to 60 days postpartum, and covers their infants up to two years of age. Eligibility is limited to families with incomes from 200 to 300 percent of the poverty level. Subscribers pay premiums equal to 2 percent of the family's annual income plus $100 for the infant's second year of coverage. As of July 1, 2004, infants born to AIM women are automatically enrolled in the Healthy Families Program (HFP) at birth, as applicable.	Staff Recommendation: It is recommended to approve the Administration's May Revision for the AIM Program. No issues have been raised. There are no affects to the General Fund from this action. Proposition 99 Funds (Cigarette and Tobacco Product Surtax Funds) are transferred to the Perinatal Insurance Fund for expenditure for the AIM Program as required by existing statute. A portion of these funds are used to obtain federal matching funds through the federal State-Child Health Insurance Program (S-CHIP), (Decrease of $3.891 million in Item 4280-101-0890. Increase transfer authority in Item 4280-111-0232 by $2.087 million. Decrease transfer authority in Item 4280-111-0233 by $1.5 million. Decrease transfer authority in Item 4280-111-0236 by $3.386 million.)

STATE OF CALIFORNIA
MANAGED RISK MEDICAL INSURANCE BOARD
1000 G STREET, SUITE 450
SACRAMENTO, CA 95814

TITLE 10. INVESTMENT. CALIFORNIA CODE OF REGULATIONS
CHAPTER 5.6. ACCESS FOR INFANTS AND MOTHERS PROGRAM

AMEND SECTIONS 2699.100; 2699.201; 2699.205; 2699.207; 2699.209; and 2699.400;

ARTICLE 1. DEFINITIONS

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Text proposed to be added for the 15-day comment period is display in double underline type.
Text proposed to be deleted for the 15-day comment period is displayed in ~~double strikeout type.~~

Section 2699.100 is amended to read:

2699.100. Definitions

(a) "Appellant" means an applicant or subscriber who has filed an appeal with the program.

(b) "Applicant" means a pregnant woman 18 years of age or older who is applying on her own behalf, or a legal guardian or a natural parent, foster parent, or stepparent with whom the child resides, who applies for coverage under the program on behalf of a child. "Applicant" also means a pregnant woman who is applying for coverage on her own behalf who is under 18 years of age, or who is an emancipated minor, or who is a minor not living in the home of a natural or adoptive parent, a legal guardian, foster parent or stepparent.

(c) "Application Date" means the date an application is sent to the program as evidenced by the U.S. postmark date on the application envelope, or documentation from other delivery services including fax delivery.

(d) "Board" means the Managed Risk Medical Insurance Board.

(e) "Coverage" means the payment for benefits provided through the program.

(f) "Disenroll" means to terminate coverage by the program.

(g) "Eligible" means the applicant is qualified to be enrolled in a participating health plan.

(h) "Enroll" means to accept an applicant as a subscriber by notifying a participating health plan to accept the applicant.

(i) "Executive Director" means the executive director for the Board.

(j) "Family member" means the following persons living in the individual's home:

(1) Children under age 21, of married or unmarried parents living in the home.

(2) The married or unmarried parents of the child or sibling children.
(3) The stepparents of the sibling children.

(4) The separate children of either an unmarried parent or a married parent or stepparent.

(5) An unborn child of the pregnant woman who is applying for coverage on her own behalf or on whose behalf an application has been submitted.

(6) Children under the age of 21, of married or unmarried parents, away at school who are claimed as tax dependents.

(7) The spouse of the pregnant woman.

(k) "Federal poverty level" means the level determined by the "Poverty Guidelines for the 48 Contiguous States and the District of Columbia" as contained in the Annual Update of HHS Poverty Guidelines as published in the Federal Register by the U.S. Department of Health and Human Services.

(l) "First trimester" means the first 13 weeks starting with the first day of a pregnant woman's last menstrual period and ending at the end of the 13th week, or the first 13 weeks of a 40-week, full-term pregnancy as documented by a licensed health care professional.

~~(l)~~(m) "Gross household income" means the total annual gross income of all family members except dependent children. Income includes before tax

earnings from a job, including cash, wages, salary, commissions and tips, self-employment net profits, Social Security, State Disability Insurance (SDI), Retirement Survivor Disability Insurance (RSDI), veterans benefits, Railroad Retirement, disability worker's compensation, unemployment benefits, alimony, spousal support, pensions and retirement benefits, grants that cover living expenses, settlement benefits, rental income, gifts, lottery/bingo winnings and interest income. Income excludes child support, public assistance program benefits such as SSI/SSP and CalWORKS payments, foster care payments, general relief, loans, grants or scholarships applied toward college expenses, or earned income of a child aged 13 or under, or a child attending school. Income does not include income exclusions applicable to all federal means tested programs such as, disaster relief payments, per capita payments to Native Americans from proceeds held in trust and/or arising from use of restricted lands, Agent Orange payments, Title IV student assistance, energy assistance payments to low income families, relocation assistance payments, victims of crime assistance program, Spina Bifida payments, earned income tax credit and Japanese reparation payments.

~~(m)~~(n)"Healthy Families Program" (HFP) means the Federal/State funded program that is operated pursuant to Title XXI of the Social Security Act and Part 6.2 (commencing with Section 12693) of Division 2 of the California Insurance Code, and that provides low cost health, dental and vision insurance coverage to eligible children.

~~(n)~~(o) "Income deduction" means any of the following:

(1) Work expenses of $90 per month for each family member except dependent children working or receiving disability workers' compensation or State Disability Insurance. If a family member earns less than $90, the deduction can only be for the amount earned.

(2) Child care expenses while a family member works or trains for a job of up to $200 per month for each family member under age 2, up to $175 per month for each family member over age 2 and disabled dependent care expenses of up to $175 for a disabled dependent living in the home.

(3) The amount paid by a family member per month for any court ordered alimony or child support.

(4) $50 for alimony payments received by the pregnant woman. If a woman receives less than $50, the deduction can only be for the amount received.

~~(o)~~(p) "Infant" means a subscriber's child born to a subscriber while the subscriber is enrolled in the program.

~~(p)~~(q) "Living in the home" means using the home as the primary place of residence.

~~(q)~~(r) "Medi-Cal" means the California health care services program under Title XIX of the Social Security Act.

~~(r)~~(s) "Medicare" means the Health Insurance for the aged and permanently disabled provided under Title XVIII of the Social Security Act; "Part A" means Hospital Insurance as defined in Title XVIII of the Social Security Act; and "Part B" means Medical Insurance as defined in Title XVIII of the Social Security Act.

~~(s)~~(t) "Participating health plan" means any of the following plans which are lawfully engaged in providing, arranging, paying for, or reimbursing the cost of personal health care services under insurance policies or contracts, medical and hospital service arrangements, or membership contracts, in consideration of premiums or other periodic charges payable to it, and that contracts with the program to provide coverage to program subscribers:

(1) A private insurer holding a valid outstanding certificate of authority from the Insurance Commissioner.

(2) A nonprofit hospital service plan qualifying under Chapter 11a (commencing with Section 11491) of Part 2 of Division 2 of the Insurance Code.

(3) A nonprofit membership corporation lawfully operating under the Nonprofit Corporation Law (Division 2 (commencing with Section 5000) of the Corporations Code).

(4) A health care service plan as defined under subdivision (f) of Section 1345 of the Health and Safety Code.

(5) A county or a city and county, in which case no license or approval from the Department of Insurance or the Department of Corporations shall be required to meet the requirements of this part.

(6) A comprehensive primary care licensed community clinic that is an organized outpatient freestanding health facility and is not part of a hospital that delivers comprehensive primary care services, in which case, no license or approval from the Department of Insurance or the Department of Corporations shall be required to meet the requirements of this part.

~~(t)~~(u) "Program" means the Access for Infants and Mothers Program.

~~(u)~~(v) "Resident" means a person who is present in California with intent to remain present except when absent for transitory or temporary purposes.

~~(v)~~(w) "State supported services" means abortion services provided to the subscribers through the program.

~~(w)~~(x) "Subscriber" means an individual who is eligible for and enrolled in the program.

~~(x)~~(y) "Subscriber contribution" means the cost to the subscriber to participate in the program.

~~(y)~~(z) "Tenses and Number". The present tense includes the past and future, and the future the present; the singular includes the plural and the plural the singular.

~~(z)~~(aa) "Time". Whenever in this chapter a time is stated in which an act is to be done, the time is computed by excluding the first day and including the last day. If the last day is a holiday it is also excluded.

NOTE: Authority cited: Section 12696.05, Insurance Code. Reference: Sections 12695, 12695.06, 12695.08, 12695.18, 12695.20, 12695.22, 12695.24, 12696 and 12698, Insurance Code.

ARTICLE 2. ELIGIBILITY, APPLICATION, AND ENROLLMENT

Section 2699.201 is amended to read:

2699.201. Application

(a) To apply for the program an individual shall submit:

(1) All information, documentation, and declarations necessary to determine program eligibility as set forth in subsection (d) of this

section; and

(2) A cashier's check or money order for fifty dollars ($50.00); and

(3) A statement signed by the applicant agreeing that if the pregnant woman is enrolled, the applicant will pay the full subscriber contribution and acknowledging that the program will take aggressive action to collect the full subscriber contribution.

(b) The applicant shall sign and date a declaration stating that the information is true and accurate to the best of his or her knowledge.

(c) The applicant will be notified in writing that the application is incomplete and what documentation is required for completion.

(d) (1) The application, entitled Access for Infants and Mothers (AIM) Application ~~(rev 6/04)~~(rev 7/07), which is incorporated by reference, shall contain the following:

(A) The pregnant woman's full name,

(B) The pregnant woman's current living address including house or building number (and unit number if applicable), street, city, county, state, and zip code, and phone number,

(C) The pregnant woman's date of birth,

(D) The pregnant woman's social security number (provision of the Social Security number is not mandatory),

(E) The pregnant woman's ethnicity and primary language (not mandatory),

(F) Certification by a staff person authorized by the Planned Parenthood Organization or a licensed or certified healthcare professional, including, but not limited to a medical doctor, doctor of osteopathy, registered nurse, physician's assistant, nurse midwife, vocational nurse, or medical assistant, that the woman on whose behalf the application is filed is pregnant,

(G) The first day of the pregnant woman's last menstrual period,

(H) A declaration that the pregnant woman is not, to the best of

the applicant's knowledge, beyond the 30th week of gestation in a current pregnancy, as of the application date,

(I) Information about whether the applicant or anyone in the household smokes,

(J) The address to which the bills for the subscriber's contribution are to be sent, if different from the current living address,

(K) The first and last name, and date of birth of the baby's father if living with the pregnant woman,

(L) Information about whether the father of the baby is married to the pregnant woman,

~~(K)~~(M) A list of all family members living in the home, their ages, and relationship to the pregnant woman,

~~(L)~~(N) A list of those family members, and their social security numbers excluding dependent children, living in the home who had income in the previous or current calendar year, (provision of the social security number is not mandatory),

~~(M)~~(O) Documentation of the total monthly gross household income for either the previous or current calendar year. For each person listed in (L) above, provide documentation for each source of income. Such documentation shall be provided for the previous or current year as indicated below:

1. For the previous calendar year:

   a. Federal tax return. If self-employed, a schedule C must be included.

   b. All of the following that are applicable and that reflect the current benefit amount: copies of award letters, checks, bank statements, passbooks, or internal revenue service (IRS) 1099 forms showing the amount of Social Security, State Disability Insurance (SDI), Retirement Survivor Disability Insurance (RSDI), veterans benefits, Railroad Retirement, disability workers' compensation,

unemployment benefits, alimony, spousal support, pensions and retirement benefits, loans to meet personal needs, grants that cover living expenses, settlement benefits, rental income, gifts, lottery/bingo winnings, dividends, or interest income.

2. For the current calendar year:

   a. A letter from the person's current employer. The letter shall be dated and written on the employer's letterhead, and shall include the following:

      i. The employee's name.

      ii. The employer's business name, business address and phone number.

      iii. A statement of the person's current gross monthly income for a period ending within 45 days of the date the program receives the document.

      iv. A statement that the information presented is true and correct to the best of the signer's knowledge.

      v. A signature by someone authorized to sign such letters by the employer. The signer shall include his or her position name or job title and shall not be the person whose income is being disclosed.

   b. Paystub or unemployment stub showing gross income for a period ending within 45 days of the date the program receives the document.

   c. If self employed, a profit and loss statement for the most recent three (3) month period prior to the date the program receives the document. A profit and loss statement must include the following:

i. Date.

ii. Name, address and telephone number of the business.

iii. Gross income, gross expenses, and net profit itemized on a monthly basis.

iv. A statement on the profit and loss, signed by the person who earned the income, which states, "the information provided is true and correct."

d. A letter or Notice of Action from the County Welfare Office issued within the last two (2) months that includes:

i. For each person for whom application is being made, a statement that the person is eligible for share-of-cost Medi-Cal,

ii. A determination of total monthly household income and monthly household income after income deductions as defined in Section 2699.100, and

iii. A determination of the number of family members living in the household.

e. All of the following that are applicable and that reflect the current benefit amount: copies of award letters, checks, bank statements, or passbooks showing the amount of Social Security, State Disability Insurance (SDI), Retirement Survivor Disability Insurance (RSDI), veterans benefits, Railroad Retirement, disability workers' compensation, unemployment benefits, alimony, spousal support, pensions and retirement benefits, loans to meet personal needs, grants that cover living expenses, settlement benefits, rental income, gifts, lottery/bingo winnings,

dividends, or interest income for the previous month.

~~(N)~~(P) The name of each family member living in the home who pays court ordered child support or court ordered alimony. The name and age of each person for whom payments are made for child care and/or disabled dependent care by a family member living in the home and the monthly amount paid. Documentation of alimony paid, child care and/or disabled dependent care expenses paid. Documentation includes copies of court orders, cancelled checks, receipts, statements from the District Attorney's Family Support Division or other equivalent document.

~~(O)~~(Q) A declaration that the pregnant woman is not a beneficiary of either no-cost Medi-Cal or Part A and Part B of Medicare,

~~(P)~~(R) A declaration that the pregnant woman has been a resident of the State of California for six (6) continuous months immediately prior to the date of the signing of the application,

~~(Q)~~(S) A declaration that the applicant will abide by the rules of participation, utilization review process, and dispute resolution process of any participating health plan in which the pregnant woman is enrolled,

~~(R)~~(T) Information about any health coverage that is in effect for the pregnant woman or will be in effect for the infant, including the name, address, and policy number of the current insurance or health plan,

~~(S)~~(U) A declaration that the pregnant woman is not, to the best of the applicant's knowledge, covered for maternity benefits in a private insurance arrangement. A pregnant woman with a separate, maternity only deductible or co-payment greater than $500 shall be deemed not covered for maternity benefits for purposes of this declaration,

~~(T)~~(V) Name, ~~and~~ address and phone number of the primary employer of each adult family member who is employed,

~~(U)~~(W) Information about health coverage available to the applicant, spouse, or father of the baby who is in the household,

~~(V)~~(X) A declaration that the applicant has reviewed the benefits offered by the participating health plans,

~~(W)~~(Y) A declaration that the applicant understands and will follow the rules and regulations of the program,

~~(X)~~(Z) A declaration that the applicant is giving permission for the program to verify family income, health insurance, residence, and other circumstances,

~~(Y)~~(AA) A declaration that the subscriber is not being, and will not be, reimbursed by any health care provider or any state and local governmental entity for payment of the subscriber contribution and that no health care provider or state or local governmental entity is paying or will pay the subscriber contribution,

~~(Z)~~(BB) An indication of the pregnant woman's first choice and second choice participating health plans,

~~(AA)~~(CC) A declaration that the subscriber agrees to pay the required subscriber contribution, even if the subscriber does not take full advantage of the coverage or services.

~~(BB)~~(DD) A declaration that the information and documentation submitted is true and correct to the best of the applicant's knowledge.

(2) The Social Security number and other personal information are needed for identification and administrative purposes.

(3) If applicable, the applicant's signed authorization to forward the application to the Medi-Cal Program in the county in which the applicant resides for a determination of eligibility for no-cost Medi-Cal.

NOTE: Authority cited: Section 12696.05, Insurance Code. Reference: Sections 12698 and 12698.05, Insurance Code.

Section 2699.205 is amended to read:

2699.205. Registration of Infants

~~(a) For infants born to subscribers who are enrolled prior to July 1, 2004, the subscriber shall register the infant as follows:~~

~~(1) Within thirty (30) days of the birth of an infant, the subscriber shall notify her health plan in writing of the following information about the infant:~~

~~(A) Name; and~~

~~(B) Date of birth; and~~

~~(C) Sex; and~~

~~(D) Weight at birth.~~

~~(2) Within thirty (30) days prior to an infant's first birthday, the subscriber shall notify the program in writing if the subscriber wishes to disenroll the infant from the program. If notification is not received, the child is automatically enrolled for the second year.~~

~~(b)~~(a) For infants born to subscribers who are enrolled on or after July 1, 2004, the subscriber shall register the infant in the Healthy Families Program as follows:

(1) Upon the birth of the infant, the subscriber shall provide to the Healthy Families Program ~~the required premium and provide~~ the following information about the infant:

(A) Name; and

(B) Date of birth; and

(C) Sex; and

(D) For infants born on or after July 1, 2007:

1. Information on whether or not the infant currently is enrolled in employer sponsored health coverage and the date coverage began; and

2. Information on whether or not the infant was previously enrolled in employer sponsored health coverage, the date coverage began, the date in which coverage terminated, and the reason for termination.

(2) The Healthy Families Program shall request the infant's birth weight and primary care provider from the subscriber.

(3) Subject to all requirements specified in the statute and regulations governing the Healthy Families Program, the infant will be enrolled in the Healthy Families Program with coverage effective on the date of the infant's birth.

NOTE: Authority cited: Section 12696.05, Insurance Code. Reference: Sections 12693.765 and 12696, Insurance Code.

Section 2699.207 is amended to read:

2699.207. Disenrollment

(a) A subscriber ~~and/or infant~~ shall be disenrolled from the program and from the program's participating health plan when any of the following occur:

(1) The subscriber so requests in writing.

(2) The subscriber becomes ineligible because:

(A) The subscriber fails to meet the residency requirement; or

(B) The subscriber has committed an act of fraud to circumvent the statutes or regulations of the program,

(C) The subscriber is no longer pregnant on her effective date of coverage. If notification to the program is received after the effective date, documentation by a licensed or certified healthcare professional must be submitted indicating the date of the miscarriage.

(D) More than 60 days have elapsed since the end of the pregnancy for which the subscriber enrolled in the program. As a condition of receiving the premium reduction described in Section 2699.400(a)(5), documentation by a licensed or certified healthcare professional must be submitted to the program indicating the date the pregnancy ended.

~~(3) The infant becomes ineligible because the infant fails to meet the residency requirement.~~

(b) ~~A subscriber shall be notified by the program in writing of the disenrollment of the subscriber and/or infant from the program, the effective date, and the reason for the disenrollment.~~
When a subscriber is disenrolled pursuant to subsection (a) of this section, the program shall notify the subscriber of the disenrollment. The notice shall be in writing and include the following information:

(1) The reason for the disenrollment.

(2) The effective date of the disenrollment.

(3) An explanation of the appeals process.

(c) ~~Except for Section 2699.207(a)(2)(C), disenrollment shall take effect at the end of the calendar month in which the request was received or at the end of a future calendar month as requested by the applicant. Disenrollment pursuant to Section 2699.207(a)(2)(C) shall take effect upon the date that would have been the effective date of coverage.~~
Disenrollment pursuant to (a)(1), shall take effect at the end of the calendar month in which the request was received or at the end of a future calendar month as requested by the subscriber.

(d) Disenrollment pursuant to (a)(2)(A), shall take effect as follows:

1. If the program provides notification to the subscriber on or before the 10th of the month, disenrollment shall take effect at the end of the calendar month.

2. If the program provides notification to the subscriber after the 10th of the month, disenrollment shall take effect at the end of the following calendar month.

(e) Disenrollment pursuant to (a)(2)(B), shall take effect as follows:

1. If the program provides notification to the subscriber on or before the 10th of the month, disenrollment shall take effect at the end of the calendar month.

2. If the program provides notification to the subscriber after the 10th of the month, disenrollment shall take effect at the end of the following calendar month.

(f) Disenrollment pursuant to (a)(2)(C), shall take effect upon the date that would have been the effective date of coverage.

(g) Disenrollment pursuant to (a)(2)(D), shall take effect on the 61st day following the date the subscriber's pregnancy ended.

~~(d)~~(h) Once a subscriber ~~and/or infant~~ is disenrolled pursuant to Section 2699.207(a), the subscriber ~~and/or infant~~ cannot be re-enrolled for the same pregnancy.

NOTE: Authority cited: Section 12696.05, Insurance Code. Reference: Sections 12696.05 and 12698, Insurance Code.

Section 2699.209 is amended to read:

2699.209. Coverage

(a) The date on which the coverage shall begin shall be no later than ten (10) calendar days from the date the applicant is enrolled. Coverage shall not begin if the pregnancy terminates prior to the effective date of coverage.

(b) Unless the subscriber is otherwise disenrolled pursuant to Section 2699.207, ~~C~~coverage in the program for the subscriber shall be for one pregnancy and shall include services following the pregnancy for sixty (60) days. ~~The subscriber shall be notified of the date her coverage ends and such notice will be provided at least twenty (20) days prior to that date.~~ The subscriber shall notify the program of the date on which the pregnancy for which she enrolled ends. She shall provide this notification by the thirtieth day after the end of the pregnancy.

~~(c) Coverage in the program for an infant born to a subscriber who is enrolled prior to July 1, 2004 shall be for two (2) years from the date of the birth of the child.~~

~~(d) Notwithstanding subsections (b) and (c) above, coverage in the program for either the subscriber or the infant will cease at disenrollment.~~

NOTE: Authority cited: Section 12696.05, Insurance Code. Reference: Sections 12696.05 and 12698.30, Insurance Code.

ARTICLE 4. SUBSCRIBER CONTRIBUTIONS AND PAYMENT FOR SERVICES

Section 2699.400 is amended to read:

2699.400. Subscriber Contributions

(a) Subscriber contributions shall be:

(1) An initial fifty dollars ($50.00) to be submitted with the application; and

(2) For subscribers who are enrolled prior to July 1, 2004, the difference between two percent (2%) of the subscriber's gross household income, less deductions, as documented with the application and fifty dollars ($50.00), which amount shall be due in twelve (12) equal monthly installments beginning with the first month following enrollment; and

(3) For infants born to subscribers who are enrolled prior to July 1, 2004, one hundred dollars ($100.00) which shall be due on the infant's first birthday unless either of following apply:

(A) The infant is disenrolled from the program prior to the infant's first birthday, or

(B) The subscriber provides written proof that the infant is current for the infant's first year immunizations. Such immunizations shall be consistent with the most current version of the Recommended Childhood Immunization Schedule jointly adopted by the Advisory Committee on Immunization Practices, the American Academy of Pediatrics, and the American Academy of Family Physicians. The written proof of completed current first year immunizations shall be signed by a licensed medical doctor, licensed doctor of osteopathy, registered nurse, or licensed physician's assistant. When such written notice is provided the amount shall be fifty dollars ($50.00).

(4) For subscribers who are enrolled on or after July 1, 2004, the difference between one and one-half percent (1.5%) of the subscriber's gross household income, less deductions, as documented with the application and fifty dollars ($50.00), which amount shall be due in twelve (12) equal monthly installments beginning with the first month following enrollment.

(5) (A) For subscribers who are enrolled on or after July 1, 2008, and no longer pregnant by the end of their first trimester, the subscriber contribution shall be reduced and shall be one-third (1/3) of the subscriber contribution calculated pursuant to subsections (a)(1) and (a)(4) of this section.

(B) As a condition of receiving this reduction, documentation by a licensed or certified healthcare professional must be submitted to the program indicating the date the pregnancy ended.

(b) There shall be no penalty for early payment of any portion of the subscriber contribution.

(c) In cases of multiple births to a subscriber, the $100 payment shall apply to each infant born to a subscriber who is enrolled prior to July 1, 2004.

(d) Subscribers shall not be reimbursed by any health care provider or state or local governmental entity for payment of the subscriber contribution and shall not have any health care provider or state or local governmental entity pay the subscriber contribution.

(e) No portion of the subscriber contribution is refundable except as provided in Sections 2699.202 and 2699.203, ~~or~~ unless the subscriber is disenrolled pursuant to Subsection 2699.207(a)(2)(C), or unless the subscriber contribution is reduced pursuant to Section 2699.400(a)(5).

(f) A federally recognized California Indian Tribal Government may make required subscriber and infant contributions on behalf of a member of the tribe.

(g) An applicant in arrears of subscriber contributions shall be sent a reminder notice. Applicants who become ninety (90) days in arrears on subscriber contributions will be reported to a credit reporting agency. If accounts are paid in full at a later date, the credit reporting agency's records shall be updated.

NOTE: Authority cited: Section 12696.05, Insurance Code. Reference: Sections 12696, 12696.05, and 12698, Insurance Code.

MANAGED RISK MEDICAL INSURANCE BOARD
RESOLUTION

After considering the public comments submitted to the Board, the Board hereby approves the final adoption of regulations for the Access for Infants and Mothers Program (AIM) to Reduce Subscriber Contributions Following 1st Trimester Miscarriages and to Clarify Procedural Requirements, Regulation Package R-2-08.

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CERTIFICATION

I, Lesley Cummings, Executive Director of the Managed Risk Medical Insurance Board, do hereby certify that the foregoing action was duly passed and adopted by the Managed Risk Medical Insurance Board at an official meeting thereof on June 23, 2008.

Dated this 23rd day of June, 2008.

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Lesley Cummings, Executive Director
Managed Risk Medical Insurance Board